

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "Pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1181 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Filed 2-20-61 et 1167

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 3 Yrs		d. STATE Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Homewood Church Home		e. COUNTY Washington		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Pike	
3. NAME OF DECEASED (Type or print) THEODORE		First F. Middle BAIR		4. DATE OF DEATH January 2, 1961	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Feb 9, 1883	
9. AGE (In years last birthday) 77 1/2 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. KIND OF BUSINESS OR INDUSTRY — — — — —	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME David H. Bair		14. MOTHER'S MAIDEN NAME Mary Ann Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Records of Homewood Church Home	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Hagerstown, Maryland			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 902-9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. GENERAL ANTERIOR SOLENOsis		FRACURE CERVICAL VERTEBRA INSTANT 10 yrs			
(b) DUE TO GENERAL ANTERIOR SOLENOsis					
(c) DUE TO GENERAL ANTERIOR SOLENOsis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from window of bedroom			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 3:30 p.m. 1-2-1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home Williamsport, Washington, Md.	
(20f. (City or town) Williamsport		(20g. (County) Washington		(20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Dr. E. W. Duthie Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. E. W. Duthie Jr.		DATE SIGNED 1/26/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/4/61		22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery	
22d. LOCATION (City, town, or county) Hanover		(State) York Co. Pa.			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS — — — — —		24a. REC'D BY REGISTRAR DATE JAN 4 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

STATE OF SOUTH DAKOTA
DEPARTMENT OF HOMELAND SECURITY

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1182 6168

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION W. Md. State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Sarah Wiley Baker</i>	Middle Last
4. DATE OF DEATH		Month January	Day 4
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Wilson's, Wash. Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Baker	
14. MOTHER'S MAIDEN NAME Mary E. Boward		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 215-14-2269		17. INFORMANT Mrs. Alma M. Burger Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>adenocarcinoma of uterus with metastasis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug. 24, 1960</i> to <i>Jan. 4, 1961</i> , that (II) (we) last saw the deceased alive on <i>Jan. 4, 1961</i> , and that death occurred at <i>8:30 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Victor L. Ramos, M.D.</i>		22b. DATE SIGNED <i>January 4, 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>Victor L. Ramos, m.d.</i>		22d. ADDRESS <i>western Md. State Hospital, Hagerstown, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 1-7-61	
23c. NAME OF CEMETERY OR CREMATORIAL Broadfording		23d. LOCATION (City, town, or county) Broadfording	
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
25a. REC'D BY REGISTRAR DATE JAN 6 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur E. Kraiss</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

138

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1183

CERTIFICATE OF DEATH

61169

1. PLACE OF DEATH

B. COUNTY

Washington

MARYLAND

B. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN lb

13 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington County Hospital (DOA)

3. NAME OF
DECEASED
(Type or print)

First
BELMONT

Middle
VIRGIL

BARTHLOW

4. SEX

Male

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Repairman

10b. KIND OF BUSINESS OR INDUSTRY

N. American Cement

5. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DIVORCED

9. DATE OF BIRTH

Nov. 21, 1921

10. AGE (In years
last birthday)

39

yrs.

IF UNDER 1 YEAR
Months Days

IF UNDER 24 HRS.
Hours Min.

13. FATHER'S NAME

John Cleveland Barthlow

14. MOTHER'S MAIDEN NAME

Sally Ann Mongan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

Yes

WW 2

16. SOCIAL SECURITY NO.

17. INFORMANT

236-28-5167 Mrs. B.V. Barthlow 719 Antietam Dr. Hagerstown, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420 Coronary Artery Thrombosis

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Angina Pectoris

INTERVAL BETWEEN
ONSET AND DEATH

40 minutes

7 days

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (This hospital) attended the deceased from..... 1958 to..... 1961, that (I) (we) last
saw the deceased alive on..... 119..... 1961, and that death occurred 9:30 P.M. from the causes and on the date stated above.

22. SIGNATURE

George Jennings
George Jennings

22c. PHYSICIAN'S
NAME (Type)

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22d. DATE
SIGNED
1/16/61

22d. ADDRESS 136 W. Washington St
Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

1/13/61

23c. NAME OF CEMETERY OR CREMATORI

Rest Haven Cemetery

23d. LOCATION (City, town or county)

(State)

Hagerstown

Md.

24. FUNERAL DIRECTOR'S SIGNATURE

Rest Haven Funeral Chapel

ADDRESS

Hagerstown, Md.

25a. REC'D BY REGISTRAR

JAN 13 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

Wm. G. Stark

63.1

sinistra parte posteriore
intestinale

10.000

10.000

10.000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1184

CERTIFICATE OF DEATH

Reg. Dist. No. 61170

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 206 Tritle Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
75X-3					
3. NAME OF DECEASED (Type or print)	First Charles	Middle Berry	Last Beall	4. DATE OF DEATH Jan. 4	Month Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1885	9. AGE (In years last birthday) 75	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Frick Co.		11. BIRTHPLACE (State or foreign country) Hedgesville, W.Va.	
13. FATHER'S NAME Charles H. Beall		14. MOTHER'S MAIDEN NAME Mollie Virginia Naylor		12. CITIZEN OF WHAT COUNTRY? Waynesboro, Pa.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 173-03-1498		17. INFORMANT Mrs. Laura Beall, 206 Tritle Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162. Bronchogenic carcinoma, right lung with mediastinal metastasis Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO (d)				INTERVAL BETWEEN ONSET AND DEATH 6months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(City or town) (County) (State)
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
21. I certify that I attended the deceased from Dec. 10, 1960, to Jan 4th, 1961, that I last saw the deceased alive on Jan 4th, 1961, and that death occurred at 1:25PM, from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) John H. Kehne, M.D. M.D. 131 West Washington Street Hagerstown, Maryland					
DATE SIGNED 1/7/1961					
ACTUAL SIGNATURE John H. Kehne, M.D.		PHYSICIAN'S NAME (Type) John H. Kehne, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 7, 1961		22c. NAME OF CEMETERY OR CREMATORIUM Green Hill Cemetery	
22d. LOCATION (City, town, or county) Waynesboro, Penna.					
23. FUNERAL DIRECTOR'S SIGNATURE H. Marlene Poe		ADDRESS Waynesboro, Penna.		24a. REC'D BY REGISTRAR JAN 10 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

WILSON COUNTY BOARD OF EDUCATION
CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1185

CERTIFICATE OF DEATH

Reg. Dist. No. 6171

1. PLACE OF DEATH a. COUNTY Washington County		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro	c. LENGTH OF STAY IN 1b 5 years.	b. COUNTY Franklin County	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fahrney-Keedy Memorial Home		d. STREET ADDRESS 153 S. Church St.			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/19/1863		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Pennsylvania			
13. FATHER'S NAME James Benedict		14. MOTHER'S MAIDEN NAME Sarah Kellar			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs. George Kunz		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 1960 to January 1961, that I last saw the deceased alive on January 6, 1961, and that death occurred at 9:14 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE G. W. Lellan M.D. ADDRESS (Street, city or town, state) Boonsboro Md. DATE SIGNED 1/9/61					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/9/61	22c. NAME OF CEMETERY OR CREMATORIAL Green Hill	22d. LOCATION (City, town, or county) Waynesboro	(State) Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Hartie Y. Green		ADDRESS Waynesboro, Pa.	24a. REC'D BY REGISTRAR DATE JAN 9 '61	24b. REGISTRAR'S SIGNATURE Curtis S. Kline	

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

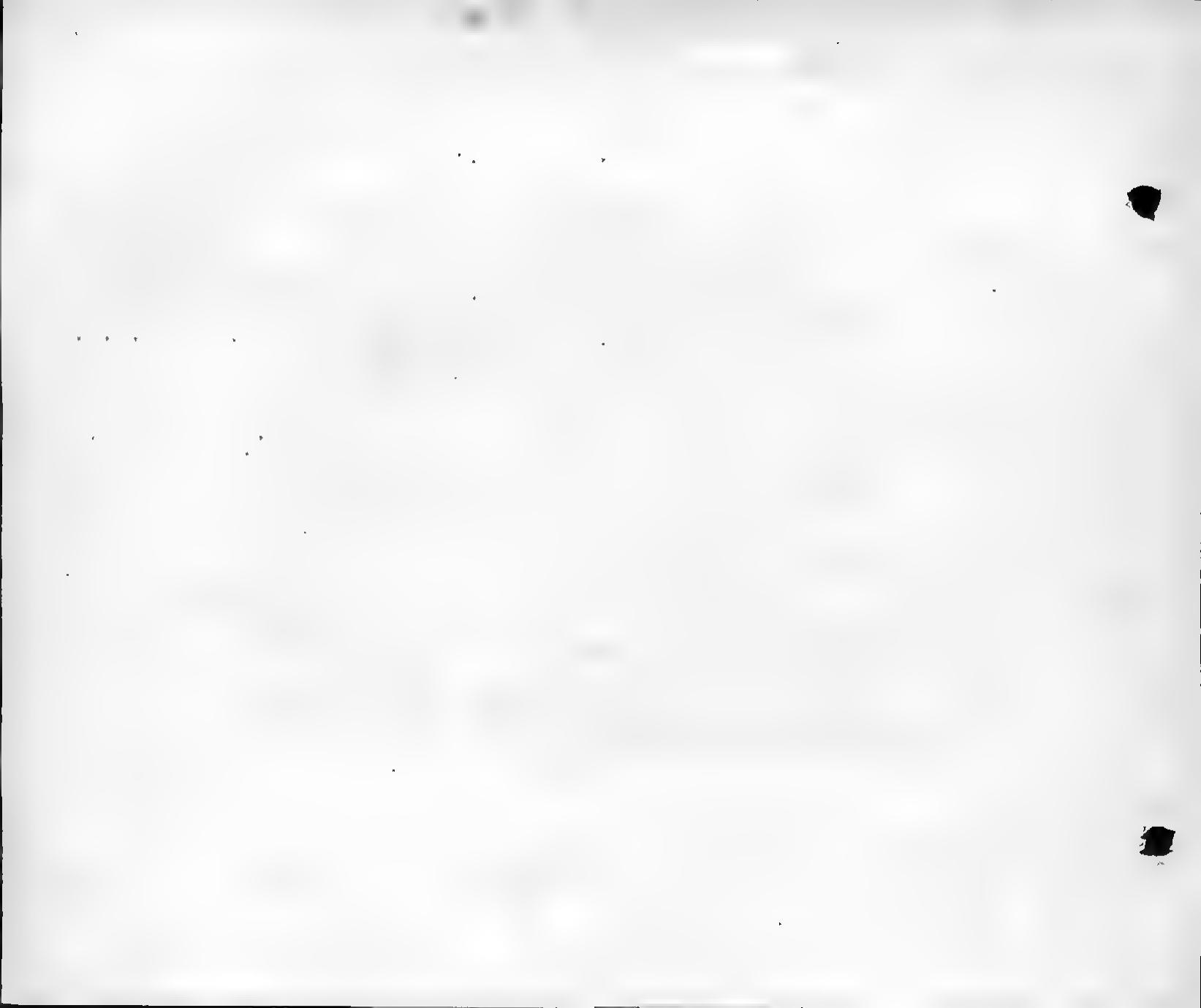
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1186

6172

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 14 Mon.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 150 East Irvin Ave		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Sarah Kathryn Bikle					january 30, 1961			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb 9, 1881	9. AGE (In Years lost b. birthday) 79 yrs	10. IF UNDER 1 YEAR Months 11 Days 21	11. IF UNDER 24 HRS Hours 21	12. IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Greencastle Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Godfrey Goetz				14. MOTHER'S MAIDEN NAME Ellen Graham				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO No		17. INFORMANT Charles G. Bikle 105 E. Irvin Ave Hagerstown, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)				19. INTERVAL BETWEEN ONSET AND DEATH 3 days				
15 8X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first		DUE TO (b) lobular pneumonia, bilateral		14 days				
		DUE TO (c) Retroperitoneal neoplasm		7 1/2 yrs.				
20. MEDICAL CERTIFICATION		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) chronic pyelonephritis		22. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 9, 1959, to January 30, 1961, that (I) (we) last saw the deceased alive on January 30, 1961, and that death occurred at 9:55 AM, from the causes and on the date stated above								
22a. SIGNATURE Victor L. Ramos, M.D.		22b. DATE SIGNED January 30, 1961						
22c. PHYSICIAN'S NAME (Type) Victor L. Ramos, M.D.		22d. ADDRESS Western Md. State Hospital, Hagerstown, Md.						
23a. BURIAL, CREMATION REMOVAL, (Specify) Burial		23b. DATE THEREOF Feby. 1/61		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION (City, town or county) Hagerstown, Md.		(State)
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K Coffman		ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE FEB 1 '61		25b. REGISTRAR'S SIGNATURE John K. Coffman		



TO HOSPITAL may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1187

CERTIFICATE OF DEATH

1173

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Hancock		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hancock, RFD#1		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS Hancock, RFD#1	
3. NAME OF DECEASED (Type or print) Frederick Fillmore		First B	Middle F
4. DATE OF DEATH 1 25 1961		Month 1	Day 25
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH March 9, 1912		9. AGE (in years last birthday) 59 48 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Orchard work	
11. BIRTHPLACE (State or foreign country) Hancock, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Millard Fillmore Bishop		14. MOTHER'S MAIDEN NAME Anne Belle Munson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 120-09-7420	
17. INFORMANT Mrs Pearl R. Landers		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 433.1 DUE TO Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH cardiac fibrillation 3 hrs cardiac arrest	
21. I certify that (I) (this hospital) attended the deceased from 1962 to 1961 , that (I) (we) last saw the deceased alive on 1960 and that death occurred at 7 AM , from the causes and on the date stated above.		22. SIGNATURE Amelia J. Haffer M.D.	
22b. DATE SIGNED Jan 25 61		22c. PHYSICIAN'S NAME (Type) Amelia J. Haffer	
22d. ADDRESS Hancock, Md.		23a. BURIAL, CREMATION REMOVAL (Specify) Burial	
23b. DATE THEREOF 1/28/61		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet New Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE Howard & Son Hancock, Md.		23d. LOCATION (City, town, or county) (State) Hancock RFD#1 Md.	
ADDRESS		25a. REGD BY REGISTRAR DATE JAN 31 '61	
25b. REGISTRAR'S SIGNATURE Amelia J. Haffer			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1188

CERTIFICATE OF DEATH

Reg. Dist. No. (1174)

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 5 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. STREET ADDRESS 416 N. Jonathan St.	
3. NAME OF DECEASED (Type or print) KATHERINE WINIFRED BOATWRIGHT		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH JANUARY 14 1961	Month Day Year		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1899
9. AGE (In years lost birthday) 61 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook	
11. KIND OF BUSINESS OR INDUSTRY Restaurant		12. BIRTHPLACE (State or foreign country) Berkeley Co., W. Va. U.S.A.	
13. FATHER'S NAME Jerry Middleton		14. MOTHER'S MAIDEN NAME Katherine Cook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT No. 1443		James Boatwright 416 N. Jonathan St. (Husband) Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 1443		DUE TO Pulmonary Embolism Arteriosclerotic heart disease Hypertensive Cardiac Disease Arteriosclerosis	
DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1/2 hrs. 2 yrs. 2 yrs. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. n. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 159 W. Washington St. Hagerstown, Md.		(County)	(State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above. ACTUAL SIGNATURE PHILIP J. HIRSHMAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-18-1961	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Hope Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. Brown		ADDRESS Martinsburg, W. Va.	24a. REC'D BY REGISTRAR DATE JAN 17 '61
			24b. REGISTRAR'S SIGNATURE C. L. THOMAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be read by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1109 1170
1. PLACE OF DEATH

a. COUNTY

Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN lb

MARYLAND

Life

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington County Hospital

3. NAME OF

First

Middle

Last

DATE OF

Month

Day

Year

DECEASED

WILBUR

STOVER

BOSTETTER

DEATH

Jan.

15

1961

4. COLOR OR RACE

White

W DOWED

DIVORCED

DATE

OF

YEAR

YES NO

5. OCCUPATION (Give kind of work)

most of working life, even if retired)

I mail carrier

U.S. Post Office

DATE

BIRTHPLACE

AGE (in years)

IF UNDER 1 YEAR

Months

6. NAME

Albert Bostetter

last birthday

IF UNDER 24 HRS

Days

Hours

7. MARRIED

NEVER MARRIED

BIRTHPLACE

Min.

Hours

Min.

8. MARRIED

W DOWED DIVORCED

Jan. 19, 1898

9. AGE (in years)

62 yrs.

last birthday

Months

Days

Hours

10. MOTHER'S MAIDEN NAME

MOTHER'S MAIDEN NAME

Hours

Min.

11. MOTHER'S MAIDEN NAME

MOTHER'S MAIDEN NAME

Hours

Min.

12. CITIZEN OF WHAT COUNTRY

CITIZEN OF WHAT COUNTRY

USA

Min.

13. MOTHER'S MAIDEN NAME

MOTHER'S MAIDEN NAME

Hours

Min.

14. MOTHER'S MAIDEN NAME

MOTHER'S MAIDEN NAME

Hours

Min.

15. MOTHER'S MAIDEN NAME

MOTHER'S MAIDEN NAME

Hours

Min.

16. SOCIAL SECURITY NO.

SOCIAL SECURITY NO.

Address

Min.

17. INFORMANT

INFORMANT

Address

Min.

217-32-5569

Mrs. W. S. Bostetter

15 Glenside Ave. Hagerstown, Md.

18. USE OF DEATH

USE OF DEATH

INTERVAL BETWEEN

ONSET AND DEATH

19. WAS AUTOPSY

WAS AUTOPSY

PERFORMED?

YES NO

20. ACCIDENT WAS UNDERLYING

ACCIDENT WAS UNDERLYING

INTERVAL BETWEEN

ONSET AND DEATH

OR CONTRIBUTING CAUSE OF DEATH

OR CONTRIBUTING CAUSE OF DEATH

INTERVAL BETWEEN

ONSET AND DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

(IF EITHER, NOTIFY MEDICAL EXAMINER)

INTERVAL BETWEEN

ONSET AND DEATH

21. TIME OF INJURY

Month, Day, Year

TIME OF INJURY

INTERVAL BETWEEN

ONSET AND DEATH

Hour a.m.

Hour a.m.

TIME OF INJURY

INTERVAL BETWEEN

ONSET AND DEATH

p.m.

p.m.

TIME OF INJURY

INTERVAL BETWEEN

ONSET AND DEATH

19

TIME OF INJURY

INTERVAL BETWEEN

ONSET AND DEATH

22. PLACE OF INJURY

PLACE OF INJURY

PLACE OF INJURY

INTERVAL BETWEEN

ONSET AND DEATH

23. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

24. PLACE OF INJURY

PLACE OF INJURY

PLACE OF INJURY

INTERVAL BETWEEN

ONSET AND DEATH

25. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

26. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

27. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

28. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

29. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

30. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

31. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

32. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

33. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

34. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

35. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

36. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

37. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

38. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

39. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

40. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

41. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

42. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

43. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

44. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

45. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

46. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

47. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

48. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

49. INJURY OCCURRED

INJURY OCCURRED

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INTERVAL BETWEEN

ONSET AND DEATH

50. INJURY OCCURRED

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INTERVAL BETWEEN

ONSET AND DEATH

51. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

52. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

53. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

54. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

55. INJURY OCCURRED

INJURY OCCURRED

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INTERVAL BETWEEN

ONSET AND DEATH

56. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

57. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

58. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

59. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

60. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

61. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

62. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

63. INJURY OCCURRED

INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

64. INJURY OCCURRED

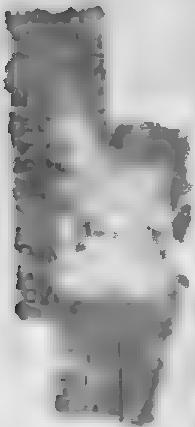
INJURY OCCURRED

INJURY OCCURRED

INTERVAL BETWEEN

ONSET AND DEATH

65. INJURY OCCURRED



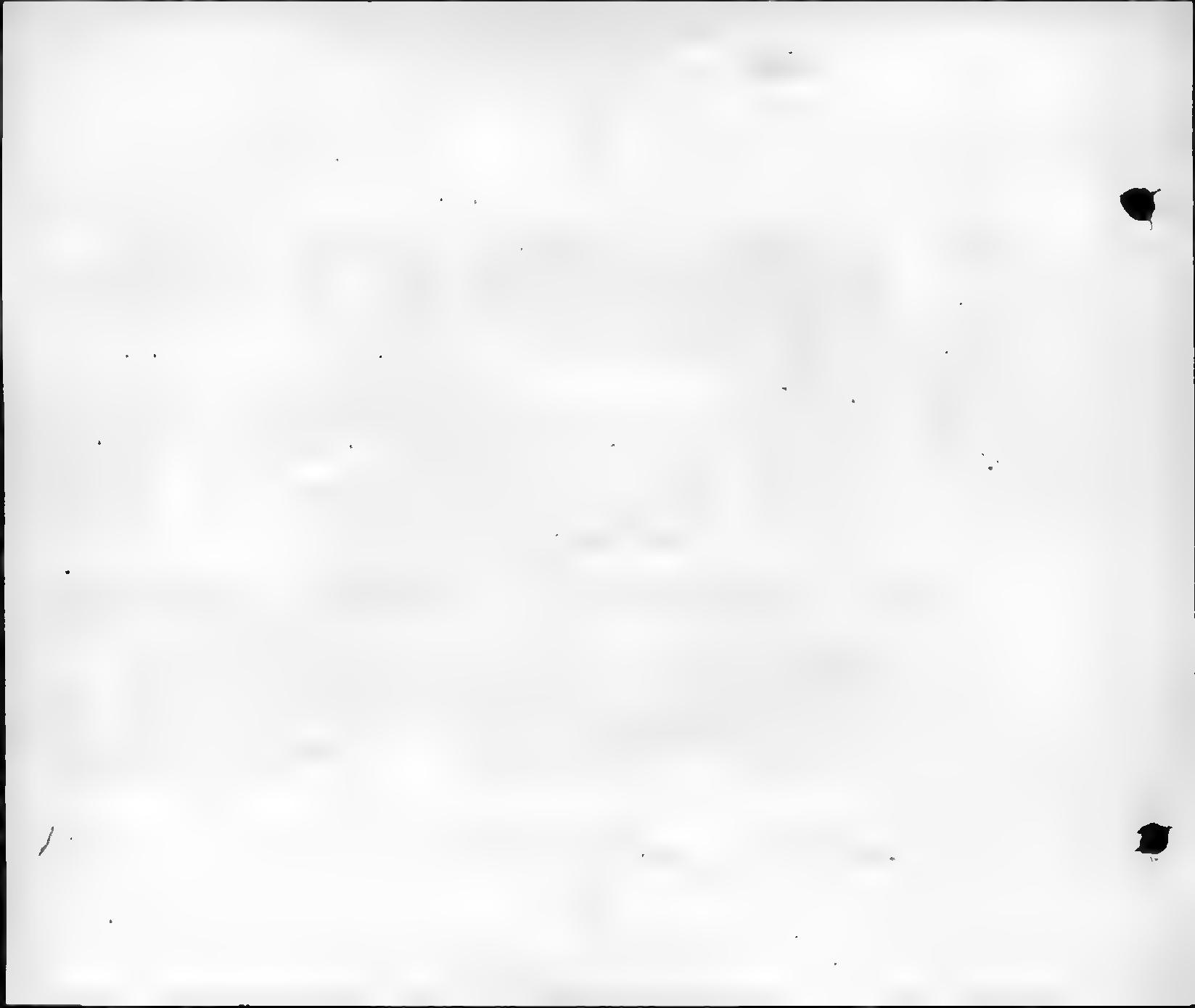
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived — If institution, Res. dence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN	
3. NAME OF DECEASED (Type or print) CLYDE		d. STREET ADDRESS RT. #3 HAGERS OWN	
3. NAME OF DECEASED (Type or print) CLYDE	First	Middle	Last
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CLERK	10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME DANIEL W. BOWERS		14. MOTHER'S MAIDEN NAME NETTIE JACOBS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 717-07-9346	17. INFORMANT MRS. STILLA R. BOWERS
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 591.0		INTERVAL BETWEEN ONSET AND DEATH Days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Cirrhosis Liver		INTERVAL BETWEEN ONSET AND DEATH Mo.	
DUE TO Ca. of the Spleen. (c)		INTERVAL BETWEEN ONSET AND DEATH WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/31/59 to 1/1/61 , that (I) last saw the deceased alive on 12/31/60 , and that death occurred at Maryland M. from the causes and on the date stated above			
22a. SIGNATURE Louis G. Craft		22b. DATE SIGNED 1/1/61	
22c. PHYSICIAN'S NAME (Type) Louis G. Craft		22d. ADDRESS 1197 - Antietam	
23a. BURIAL, CREMATION EMBALMING (Specify) CREMATION		23b. DATE THEREOF 1/7/61	
23c. NAME OF CEMETERY OR CREMATORIAL REST HAVEN CEM.		23d. LOCATION (City, town, or county) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Horowitz, Hagerstown, Md.		25a. RECEIVED BY REGISTRAR DATE JAN 9 1961	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL
may be rendered by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

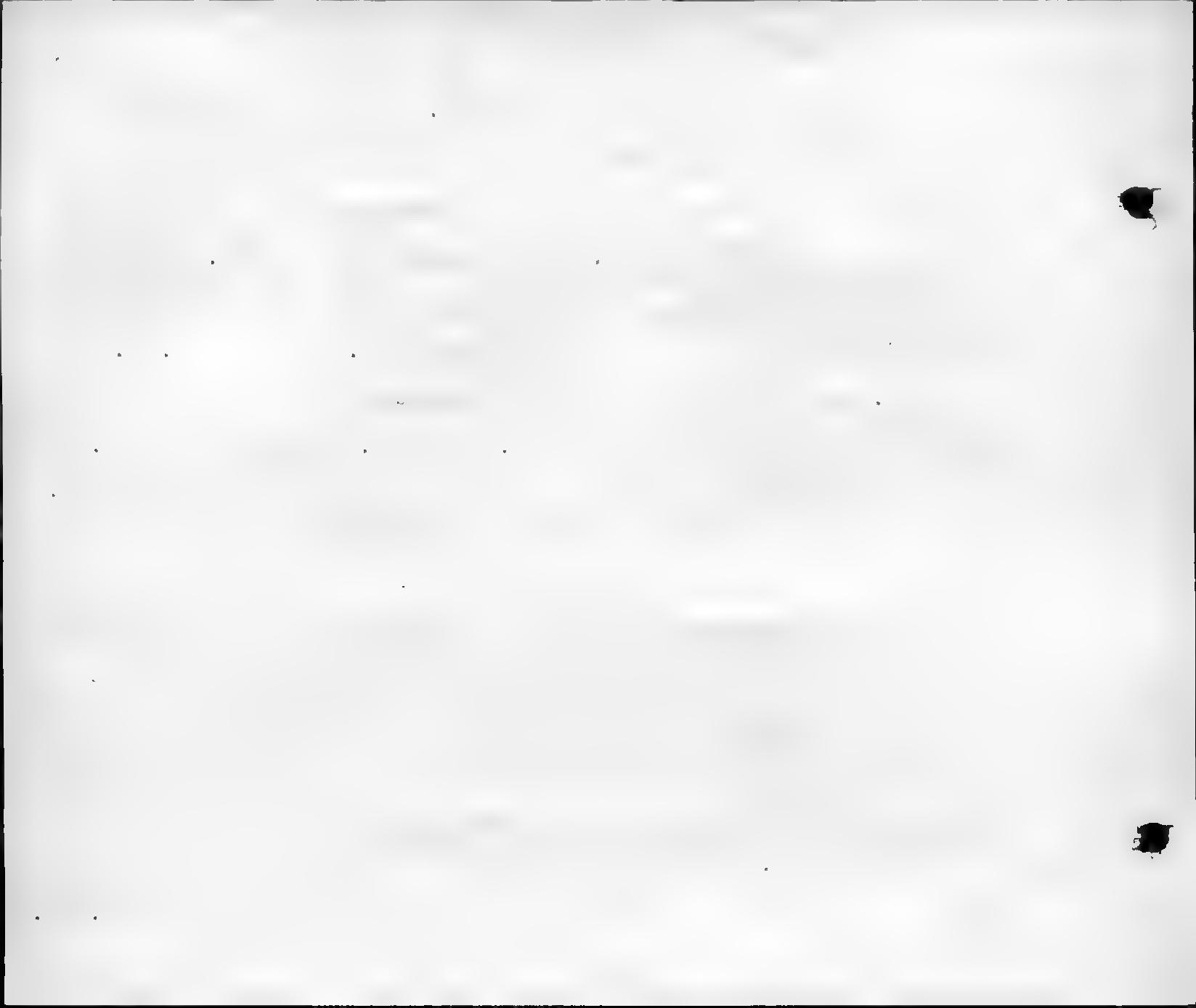
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1191

CERTIFICATE OF DEATH

1178

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 6 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Hagerstown #5	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Clifford N.	Middle	Last Bowman
4. DATE OF DEATH	Month Jan.	Day 2,	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3/16/1877
9. AGE (in years last birthday) 83 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Boilermaker		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Funkstown Md.	
13. FATHER'S NAME George I. Bowman		14. MOTHER'S MAIDEN NAME Molly Bowers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-12-1078 17. INFORMANT Mrs. Clifford N. Bowman, Hagerstown Md., #5	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause last. b) Fractured Left Humerus and Fractured Left Elbow		19. INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours	
b) Fractured Left Humerus and Fractured Left Elbow		20. WAS AUTOPIST PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) Pain in back		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Pain in back	
20c. TIME OF INJURY Hour 12 p.m.	Month 12 Days 19 Year	20d. INJURY OCCURRED White Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) Hagerstown
20f. (City or town) Hagerstown	(County) Washington	(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 12-20-60 to 1-2-61, 1961, that (I) (we) last saw the deceased alive on 1-1 1961, and that death occurred at 12:45 A.M. from the causes and on the date stated above			
22a. SIGNATURE Charles F. Hoss		22b. DATE SIGNED 1-2-61	
22c. PHYSICIAN'S NAME (Type) Charles F. Hoss, M.D.		22d. ADDRESS 217-12-1078	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/4/61	23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg	23d. LOCATION (City, town, or county) (State) Smithsburg, Washington Co., Md.
24. FUNERAL DIRECTOR'S SIGNATURE Walter Y. Grose, Mayneboro, Pa.		25a. REC'D BY REGISTRAR DATE JAN 5 '61	
		25b. REGISTRAR'S SIGNATURE Eveline E. Krause	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

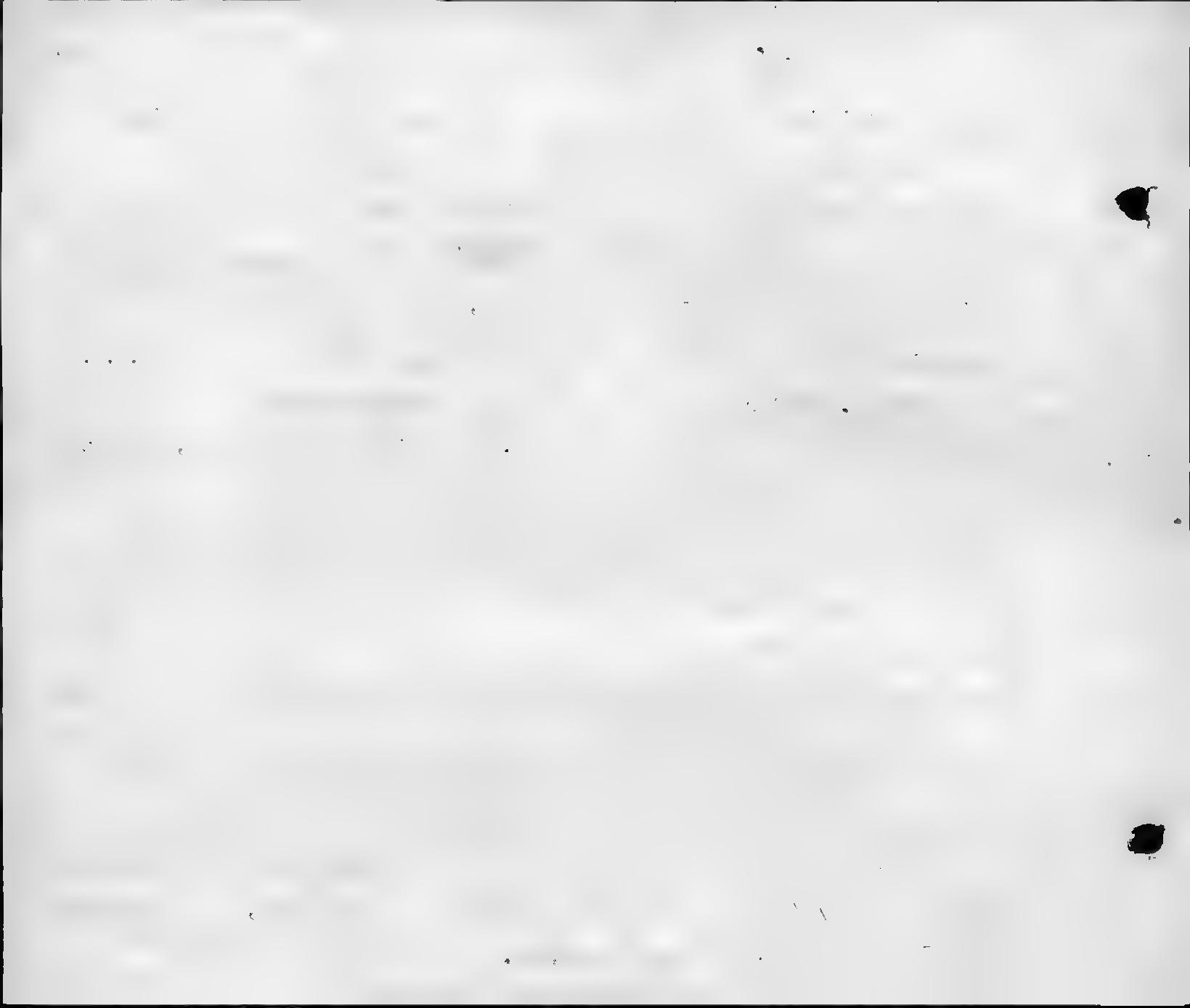
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1192

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		b. COUNTY Washington	
c. LENGTH OF STAY IN lb 46 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 918 The Terrace		d. STREET ADDRESS 918 The Terrace	
3. NAME OF DECEASED (Type or print) MAUDE		4. DATE OF DEATH January 30 1961	
5. SEX Female		5. COLOR OR RACE White	
6. MARRIED WIDOWED		7. NEVER MARRIED DIVORCED	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. DATE OF BIRTH May 18, 1873	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Walter D. Collier		14. MOTHER'S MAIDEN NAME Theresa Duffett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from NOV 20, 1960 to JAN 30, 1961, that (I) (we) last saw the deceased alive on JAN 30, 1961, and that death occurred at 3 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 1/3/61	
22a. SIGNATURE Lloyd A. Hoffman		ATTENDING PHYS M.D. MED DIRECTOR STAFF PHYS.	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		22d. ADDRESS 279 N. Potowmack St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/2/1961	
23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION (City, town or county) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home R. Franklin Rouzer		25a. REC'D BY REGISTRAR DATE FEB 2 '61	
25b. REGISTRAR'S SIGNATURE Clinton S. Franklin			



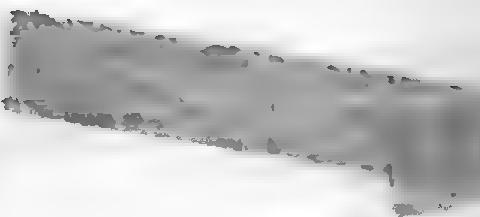
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

O HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be read by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
15M 1/59

1. PLACE OF DEATH a. COUNTY		Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE		Md		Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Hagerstown		PC#4		e. STREET ADDRESS		Hagerstown RD4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First RAYMOND		Middle BUTERBAUGH		Last H		f. DATE OF DEATH		Month Jan	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday) 73		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Retired carpenter				Websters Mills Pa		U.S.A.					
13. FATHER'S NAME		George Buterbaugh		14. MOTHER'S MAIDEN NAME		Nettie Kaysper					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		mrs mary twiss		Address			
		217-03-9130						R 10# 1 Hershey Pa			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion				INTERVAL BETWEEN ONSET AND DEATH			
420.0		DUE TO		Cyst of the heart		5 yrs					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b)		DUE TO							
		(c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that (I) (this hospital) attended the deceased from 12-1-69 to 1-4-69, that (I) (we) last saw the deceased alive on 1-5-69, and that death occurred 1-4-69, from the causes and on the date stated above.											
22a. SIGNATURE		M.D.		ATTENDING PHYS		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
D. E. D.											
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		Hagerstown Md							
J. E. W. D.		Hagerstown Md									
23a. BLR. OR CREMATION REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION (City, town, or county)		(State)			
Funeral Jan 7/61		Broadfording		Washington Co							
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 6 '61		25b. REGISTRAR'S SIGNATURE					
A. E. Munnell		Greencastle Pa				Arthur S. Thomas					



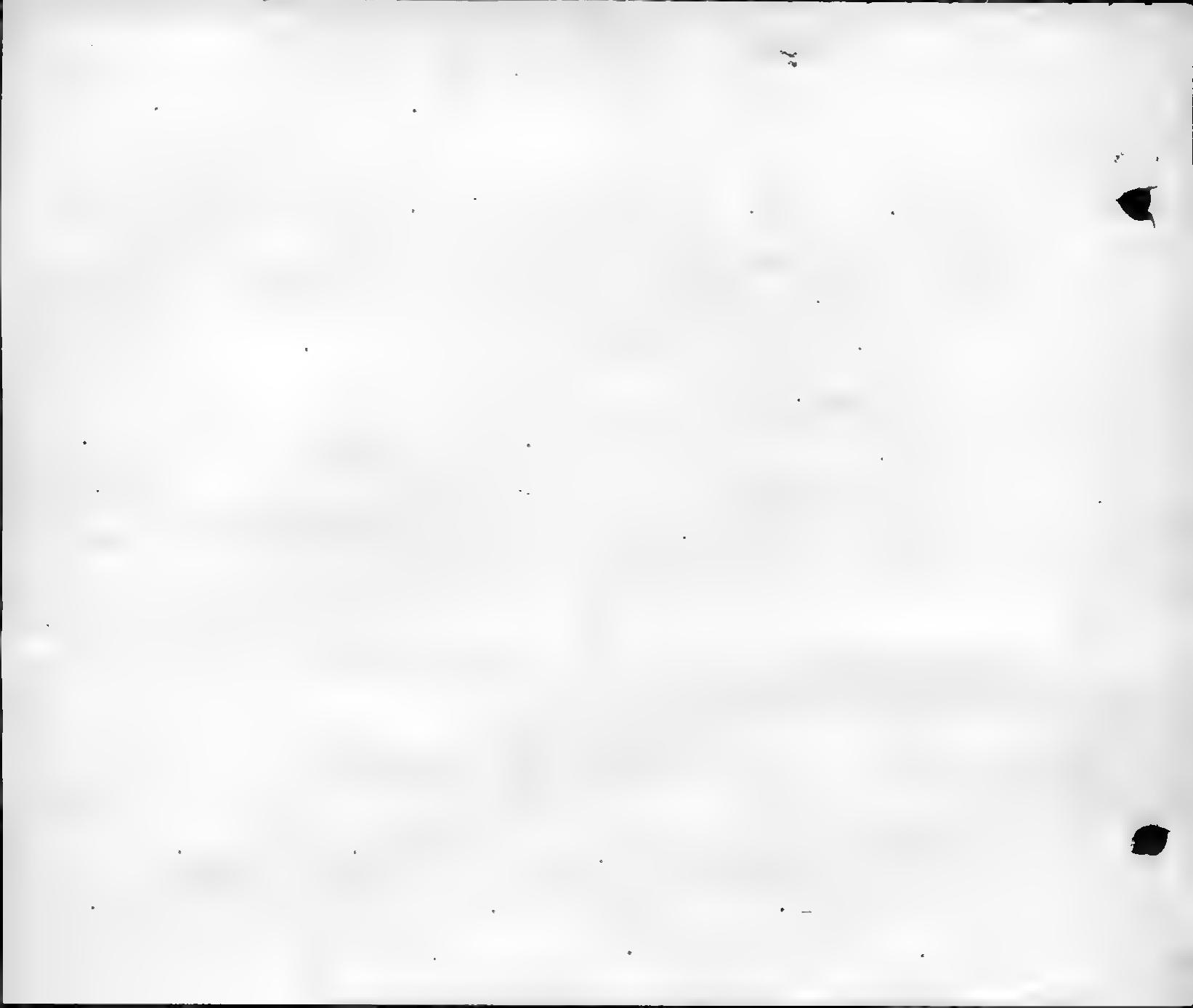
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1194

CERTIFICATE OF DEATH

(1180)

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 59 yrs		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Wash.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 127 N. Cannon Ave.,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 127 N. Cannon Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Frank		First Middle Derrick		Last Byrd		4. DATE OF DEATH 1	Month 8	Day 19	Year 61						
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 2, 1884		9. AGE (In years last birthday) 77 6 yrs							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY carpenter		11. BIRTHPLACE (State or foreign country) Bluefield Va.		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Derrick Byrd		14. MOTHER'S MAIDEN NAME unknown													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-09-7544		17. INFORMANT Mrs. Maxine Guessford		Address Hagerstown Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b)		Philmony Dubbloom Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 7 months									
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (c)		DUE TO Aturclosis Phene				4 hrs.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Regional Arteria - Left						4 yrs.									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County) Md.		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 23, 1961</u> to <u>Aug 8, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 5, 1961</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above															
22a. SIGNATURE Philip J. Hirshman, M.D.		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. ADDRESS 159 W. Washington St. Hagerstown, Maryland		22b. DATE SIGNED 1/19/61									
23a. BURIAL CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 1-11-61		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION (City, town, or county) Hagerstown		(State) Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JAN 11 '61		25b. REGISTRAR'S SIGNATURE C. E. - 2 Trans									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1195

CERTIFICATE OF DEATH

(1181)

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 63 years		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington				
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 112 John Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First William	Middle Robert	Last Campbell	4. DATE OF DEATH January 1 1961	Month Year	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1889	9. AGE (In years last birthday) 71 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yard Superintendent		10b. KIND OF BUSINESS OR INDUSTRY Coal Company		11. BIRTHPLACE (State or foreign country) Luray, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Robert L. Campbell		14. MOTHER'S MAIDEN NAME Ella Jefferson		15. ADDRESS Hagerstown, Maryland								
16. WAS DECEASED EVER IN J. S. ARMED FORCES? (Yes, no, or unknown) no		17. SOCIAL SECURITY NO. 214-09-2774		18. INFORMANT Mrs. Myrtle Morris		19. INTERVAL BETWEEN ONSET AND DEATH 3 days						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Sept 13 1960		(County) Johns		(State) 1961		
21. I certify that (I) (this hospital) attended the deceased from Sept 13 1960 to Jan 1 1961 , that (I) (we) last saw the deceased alive on Jan 1 1961 , and that death occurred at 103rd , from the causes and on the date stated above.								22b. DATE SIGNED 1/3/61				
22a. SIGNATURE Philip J. Mirshman		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. Philip J. Mirshman, M.D.		22d. ADDRESS 159 W. Washington St. Hagerstown, Maryland								
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 1/4/1961		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Lawn Cemetery		23d. LOCATION (City, town, or county) Hagerstown		(State) Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE Enter - Rouzer Funeral Home		ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR JAN 6 '61		25b. REGISTRAR'S SIGNATURE Clara S. Kraus						
VR A15 (4) 1SM 9/59												

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1196

116

1. PLACE OF DEATH a. COUNTY Washington			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 4 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonesboro		
3. NAME OF DECEASED (Type or print) George			4. DATE OF DEATH Month Jan. Day 15 Year 1961		
5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH Oct. 19 1881		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farm		
13. FATHER'S NAME Otho Churcley			11. BIRTHPLACE (State or foreign country) Sharpsburg Md.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		
17. INFORMANT Mrs. Edna Viola Churcley			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]. PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 42000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Acute respiratory infection with asthma		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 5 yrs		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (This hospital) attended the deceased from 7 Jan. 1961 to 15 Jan. 1961, that (I) (we) last saw the deceased alive on 14 Jan. 1961, and that death occurred at 1354 from the causes and on the date stated above.			22b. DATE SIGNED 17 Jan 61		
22a. SIGNATURE FF Lusby			M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) FF Lusby			22d. ADDRESS 231 N Polkman St Hagerstown Md.		
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 18-61		23c. NAME OF CEMETERY OR CREMATORIAL Mt. View Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE Albert Lusk Williamsport Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 19 '61	
				25b. REGISTRAR'S SIGNATURE Clinton S. Harter	



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TO DEPUTY SHERIFF: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

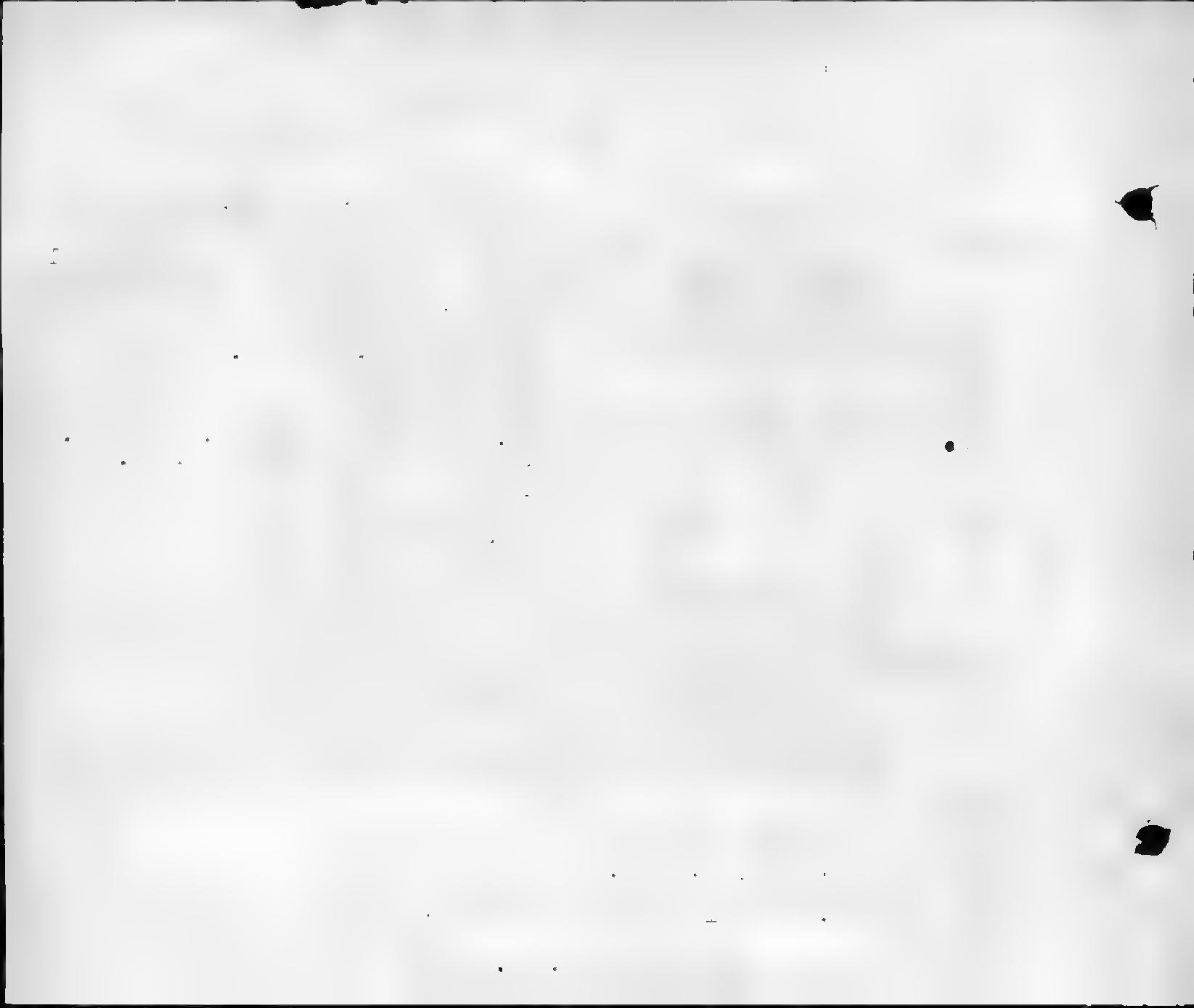
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1197 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(1183)

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b		b. COUNTY WASHINGTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 876 Virginia Avenue			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		
3. NAME OF DECEASED (Type or print) JOHN SAMUEL CLABAUGH			d. STREET ADDRESS 876 Virginia Avenue		
4. SEX Male	5. COLOR OR RACE White	6. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1898	9. AGE (in years last birthday) 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor & Flagman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Hedgesville, West Va.	
13. FATHER'S NAME Edward Clabaugh			14. MOTHER'S MAIDEN NAME Emma Bloom		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Edna Beard (Sister)	
1674 Wm. Penn Ave. Conemaugh, Pa. <small>Address</small> <small>INTERVAL BETWEEN ONSET AND DEATH</small> 1 hour					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION, old and recent					
DUE TO (b) MYOCARDIAL INFARCTION, old and recent					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <i>J. E. D. D.</i>		DATE SIGNED 1-11-61			
EXAMINER'S NAME (Type) E. W. DITTO, JR., M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 14, 1961		22c. NAME OF CEMETERY OR CREMATORIUM Hedgesville Cemetery	
22d. LOCATION (City, town, or county) (State) Hedgesville West Virginia					
23. FUNERAL DIRECTOR'S SIGNATURE H. K. Brown		ADDRESS Martinsburg, W. Va.		24a. REC'D BY REGISTRAR DATE JAN 13 '61	
24b. REGISTRAR'S SIGNATURE C. E. S. Krause					



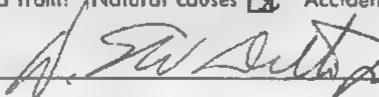
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

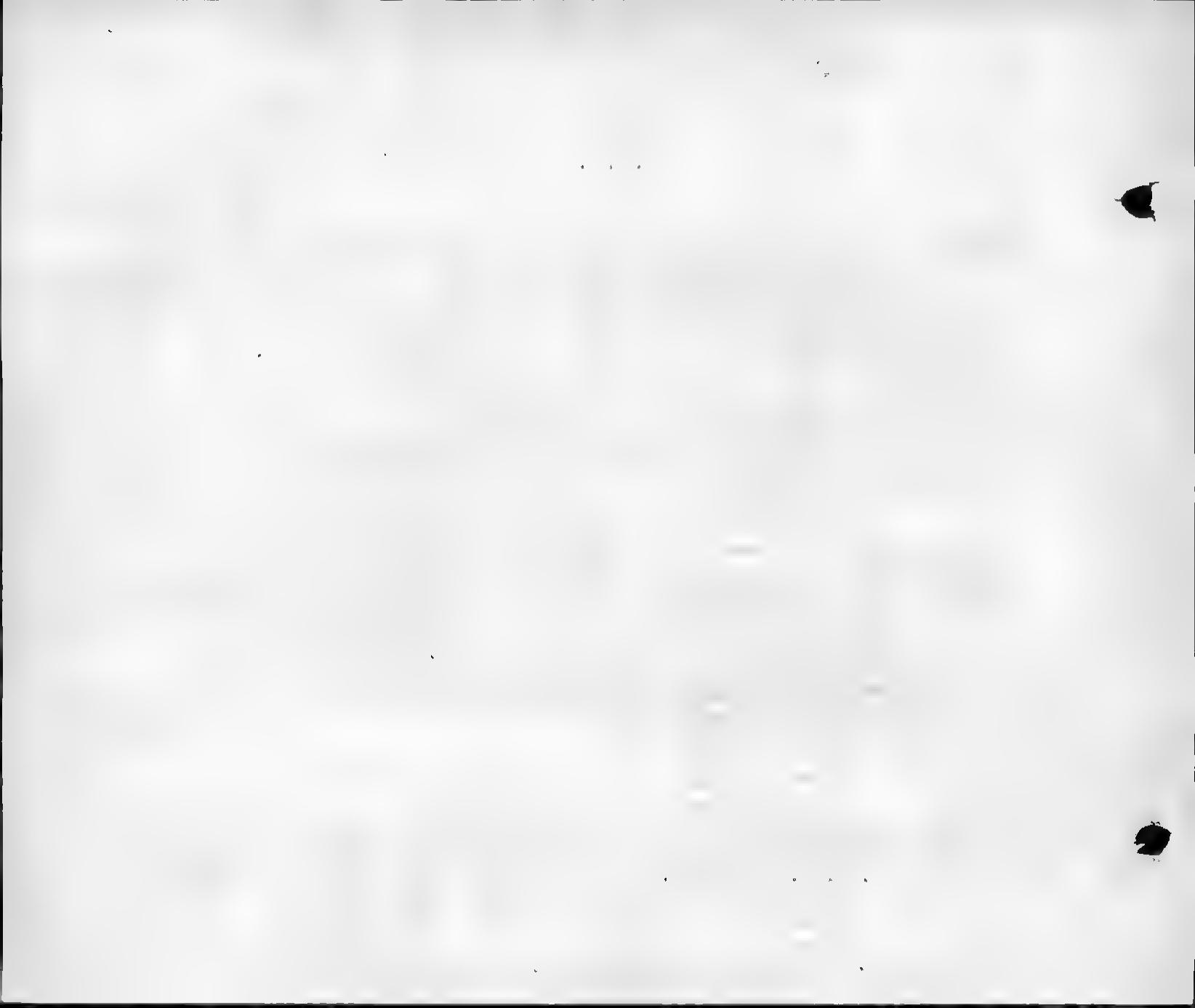
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

01184

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1198 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY Washington			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b D.O.A.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE Maryland			b. COUNTY Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital									c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown						
3. NAME OF DECEASED (Type or print) LOTTIE			First MAE			Middle CLOPPER			4. DATE OF DEATH January 17 1961			Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED WIDOWED		NEVER MARRIED DIVORCED		8. DATE OF BIRTH April 12 1882		9. AGE (In years at birthday) 78 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Keyser Mineral Co W. Va				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Sanford Baker						14. MOTHER'S MAIDEN NAME Sarah Allalong									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None			17. INFORMANT Mrs Gladys Faulcrath			Address Baltimore 14 Ward, Land 3208 Overland Ave						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Occlusion</u>									INTERVAL BETWEEN ONSET AND DEATH 4 mo. 1st						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>Arteriosclerotic Heart Disease</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]												
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town)		(County)		(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE 									DATE SIGNED 1-18-61						
EXAMINER'S NAME (Type) Dr. E. J. Dito, Jr.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>												
			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>												
			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 1/21/61			22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery			22d. LOCATION (City, town, or county) Hagerstown Wash Co Md.			(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.									24a. REC'D BY REGISTRAR DATE JAN 23 '61						
									24b. REGISTRAR'S SIGNATURE Arthur L. Krause						



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

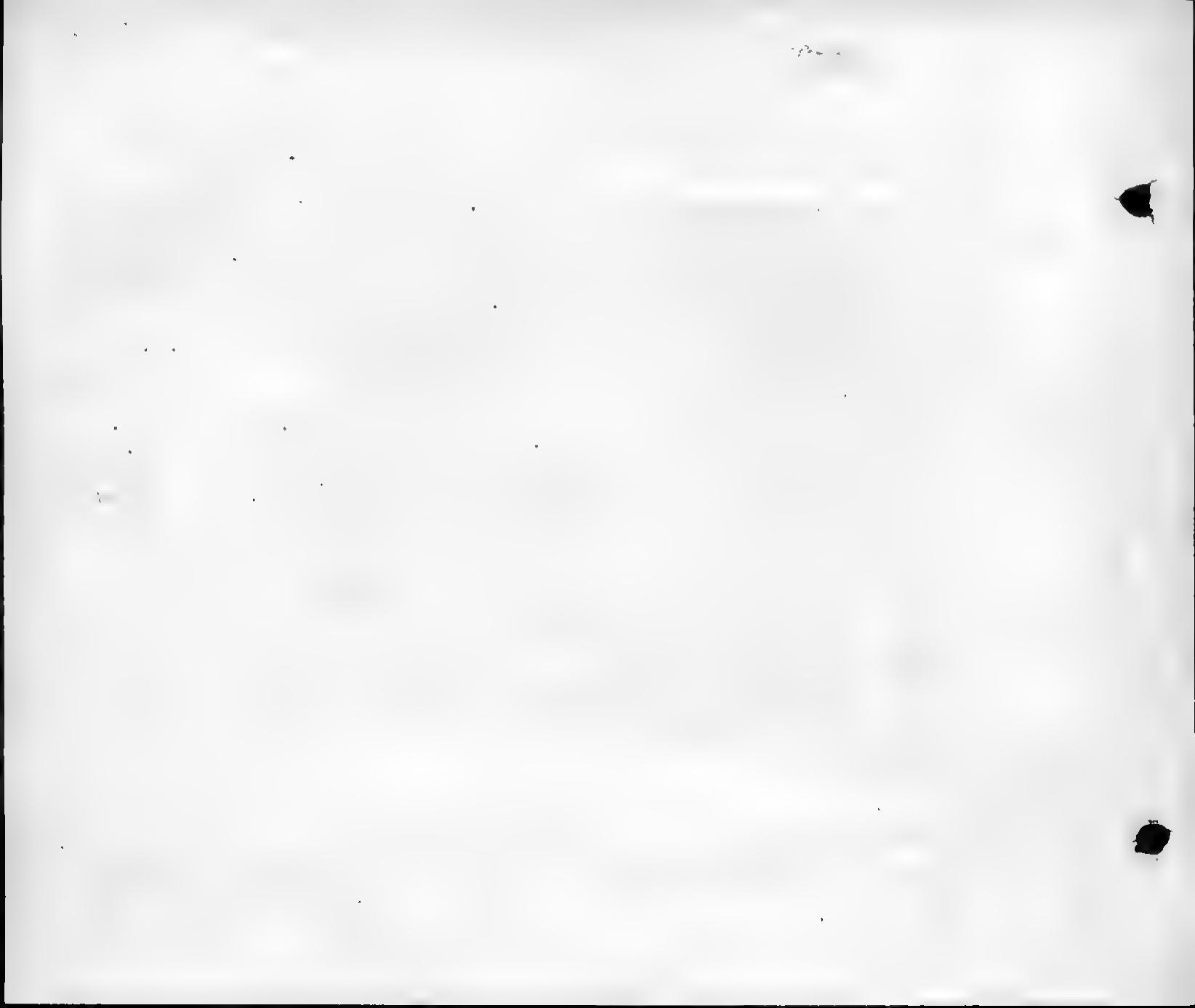
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

(1185)

CERTIFICATE OF DEATH

1199

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b One week		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md.		d. STREET ADDRESS 7 S. Artizan Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ida	Middle Florentine	Last Coakley	4. DATE OF DEATH Jan. 4	Month 1961	Day 4	Year 1961		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17 1879	9. AGE (In years last birthday) 81	10. IF UNDER 1 YEAR Months 2	11. IF UNDER 24 HRS Hours 17	12. IF UNDER 24 HRS Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Williamsport Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James E. Guessford		14. MOTHER'S MAIDEN NAME Mary Potts							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Guy Coakley		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) Acute Congestive Heart failure DUE TO (c) Atherosclerotic C.U.D.		19. INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Williamsport		(County) Washington	(State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from Aug. 1960 to Jan. 1961, that (I) (we) last saw the deceased alive on Jan. 1961, and that death occurred at M., from the causes and on the date stated above.								22b. DATE SIGNED 1-6-61	
22a. SIGNATURE M.E. Bykert		M.D.	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) M.E. Bykert		22d. ADDRESS 28 W. Potowmack Williamsport Md.							
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 7 1961		23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Cemetery		23d. LOCATION (City, town, or county) Williamsport Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE: Alfred Z. Leaf Williamsport, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 10 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be received by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1200

303

1186

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 9Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 03 2003 Jefferson Blvd	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2003 Jefferson Blvd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HAZEL PAULINE COLER		First	Middle	Last	4. DATE OF DEATH January 23 1961	Month	Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1900	9. AGE (In years last birthday) 60 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Wynesboro		12. CITIZEN OF WHAT COUNTRY? Franklin Co., Pa USA	
13. FATHER'S NAME John Cordell				14. MOTHER'S MAIDEN NAME Nora Kaetzel		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mr. Charles E. Comer, 2003 Jefferson Blvd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO 420.0 Diseases of heart, lungs and liver		19. INTERVAL BETWEEN ONSET AND DEATH - months					
(c) Diseases of heart, lungs and liver							
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Hypertensive vascular Disease		20c. TIME OF INJURY Month Day Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1961, to Jan 22, 1961, that (I) (we) last saw the deceased alive on 1/22/61, and that death occurred at 2:30 P.M. from the causes and on the date stated above							
22a. SIGNATURE Edward W. Ditto III		22b. DATE 1/23/61		22c. ATTENDING M.D. PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
22d. ADDRESS Edward W. Ditto III, M.D.				22e. ADDRESS 217 W. Washington St. Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/25/61		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerst... Wash Co. Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md				25a. REC'D BY REGISTRAR DATE JAN 27 '61		25b. REGISTRAR'S SIGNATURE Guthrie L. Keenan	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1201

CERTIFICATE OF DEATH

118

1. PLACE OF DEATH o COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Nd. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 16 60 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Memorial Hospital		d. STREET ADDRESS 633 N. L. Berry St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eva		First	Middle	Last	4. DATE OF DEATH Month January Day 13 Year 1961
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 3, 1884		9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bridgeport, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Josiah Stouffer		14. MOTHER'S MAIDEN NAME Susan Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) no		16. SOCIAL SECURITY NO 214-09-0087		17. INFORMANT Edward Elliott, Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33 / X Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cerebral hemorrhage, recurrent		19. INTERVAL BETWEEN ONSET AND DEATH 24-36 hours	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Arteriosclerotic heart disease, cerebral		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> p. m. ----- 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-7-57 to 1957, death on 1-11-61, that (I) (we) last saw the deceased alive on 1-11-61, and that death occurred at 2:45 A.M. from the causes and on the date stated above		22a. SIGNATURE Robert F. Kadle		22b. DATE SIGNED January 16, 1961	
22c. PHYSICIAN'S NAME (Type) Robert F. Kadle		22d. ADDRESS 318 North Potomac Street Hagerstown, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 1-19-61		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION (City, town, or county) Hagerstown, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		ADDRESS		25a. REC'D BY REGISTRAR JAN 18 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL: The aw requires that the death certificate be executed within 24 hours after death. Page 4
 may be rendered by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1188

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Washington MARYLAND		Maryland Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Circleville		c. LENGTH OF STAY IN 1b 7 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Convalescent Home Inc.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. STREET ADDRESS Not Known		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First J.		Middle Harry	
Last Finfrock		Month January	Day 13
5. SEX		6. COLOR OR RACE	
Male		White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/>		Divorced <input checked="" type="checkbox"/>	
10a. JEWISH OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber	
10c. BIRTHPLACE (State or foreign country) Franklin Co. Penna		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Finfrock		14. MOTHER'S MAIDEN NAME Susan Brightwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address Mr. Frank B. Finfrock, Greensboro, Pa	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1 - 0 Conditions, if any, which give rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 19, 1961, to Jan 23, 1961, that (I) (we) last saw the deceased alive on Jan 22, 1961, and that death occurred at <u>Greencastle</u> from the causes and on the date stated above.		21b. DATE SIGNED 1/24/61	
22a. SIGNATURE <u>David R. Brewer</u>		22b. ADDRESS 22c. PHYSICIAN'S NAME (Type) David R. Brewer	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-27-1961	
23c. NAME OF CEMETERY OR CREMATORIAL Petal Hill Cemetery		23d. LOCATION (City, town, or county) Greencastle Franklin Penna	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Zimmerman</u>		25a. ADDRESS Greencastle, Pa	
25a. REC'D BY REG STAR DATE JAN 26 '61		25b. REGISTRAR'S SIGNATURE C. H. S. T. 2. times	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

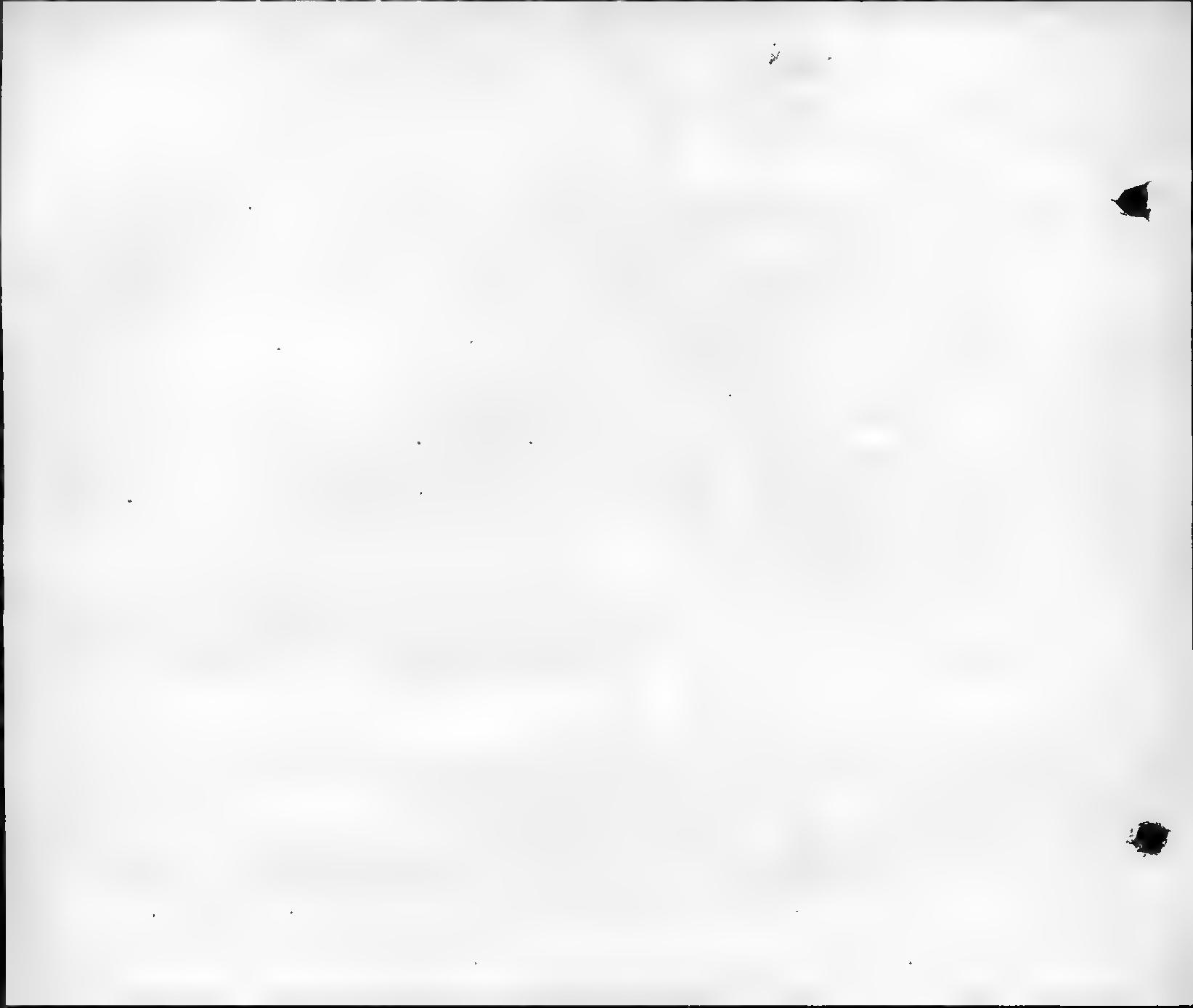
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1203 (118)

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital			d. STREET ADDRESS 26 Elizabeth St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Alfred	Middle Walter	Last Furstenberg	4. DATE OF DEATH January 30 1961	Month Day Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH November 6, 1890	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cumberland Md.	
13. FATHER'S NAME William Furstenberg			14. MOTHER'S MAIDEN NAME Florence Keller		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lela C. Furstenberg Hagerstown Md.	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 540.1 DUE TO <i>Bleeding, peptic ulcer</i> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arterio sclerotic heart disease</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
21. I certify that (I) (this hospital) attended the deceased from <u>9 Jan 1961</u> to <u>30 Jan 1961</u> , that (I) (we) last saw the deceased alive on <u>30 Jan 1961</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <i>Edmund Goodlamb</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/31/61	
22c. PHYSICIAN'S NAME (Type) <i>Edmund Goodlamb</i>		22d. ADDRESS <i>Hagerstown, Md.</i>			
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 2-2-61		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	
23d. LOCATION (City, town, or county) Hagerstown, Md.				(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Lincoln & Son		ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR FEB 1 '61	
				25b. REGISTRAR'S SIGNATURE <i>John S. Kraus</i>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 1204 CERTIFICATE OF DEATH

Reg. Dist. No. (1196)

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Pennsylvania b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro, Md.		c. LENGTH OF STAY IN lb 8/1/58-1/4/61	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fahrney-Keedy Memorial Home for the Aged		Mont Alto d. STREET ADDRESS 75X-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Harry	Middle Clayton	Last Hammond
4. DATE OF DEATH	Month 1	Day 4	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1869
9. AGE (In years lost birthday) 91 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Foreman, Southern Pipe Line		11b. KIND OF BUSINESS OR INDUSTRY 11c. BIRTHPLACE (State or foreign country) Benevola, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME David O. Hammond		14. MOTHER'S MAIDEN NAME Margaret Murray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 17. INFORMANT George Koons, Boonsboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) + Conditions, if any, which give rise to immediate cause (a), stating the under- lying cause lost (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 6 yrs. 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> or work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 15, 1960, to January 4, 1961, that I last saw the deceased alive on January 3, 1961, and that death occurred at 11:45 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE G. W. K. Van		ADDRESS (Street, city or town, state) Boonsboro Md.	
PHYSICIAN'S NAME (Type)		DATE SIGNED 1/4/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/6/61	
22c. NAME OF CEMETERY OR CREMATORIUM Burns Hill		22d. LOCATION (City, town, or county) (State) Waynesboro, Franklin Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter V. Young, Waynesboro, Pa.		24a. REC'D BY REGISTRAR JAN 5 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Price	



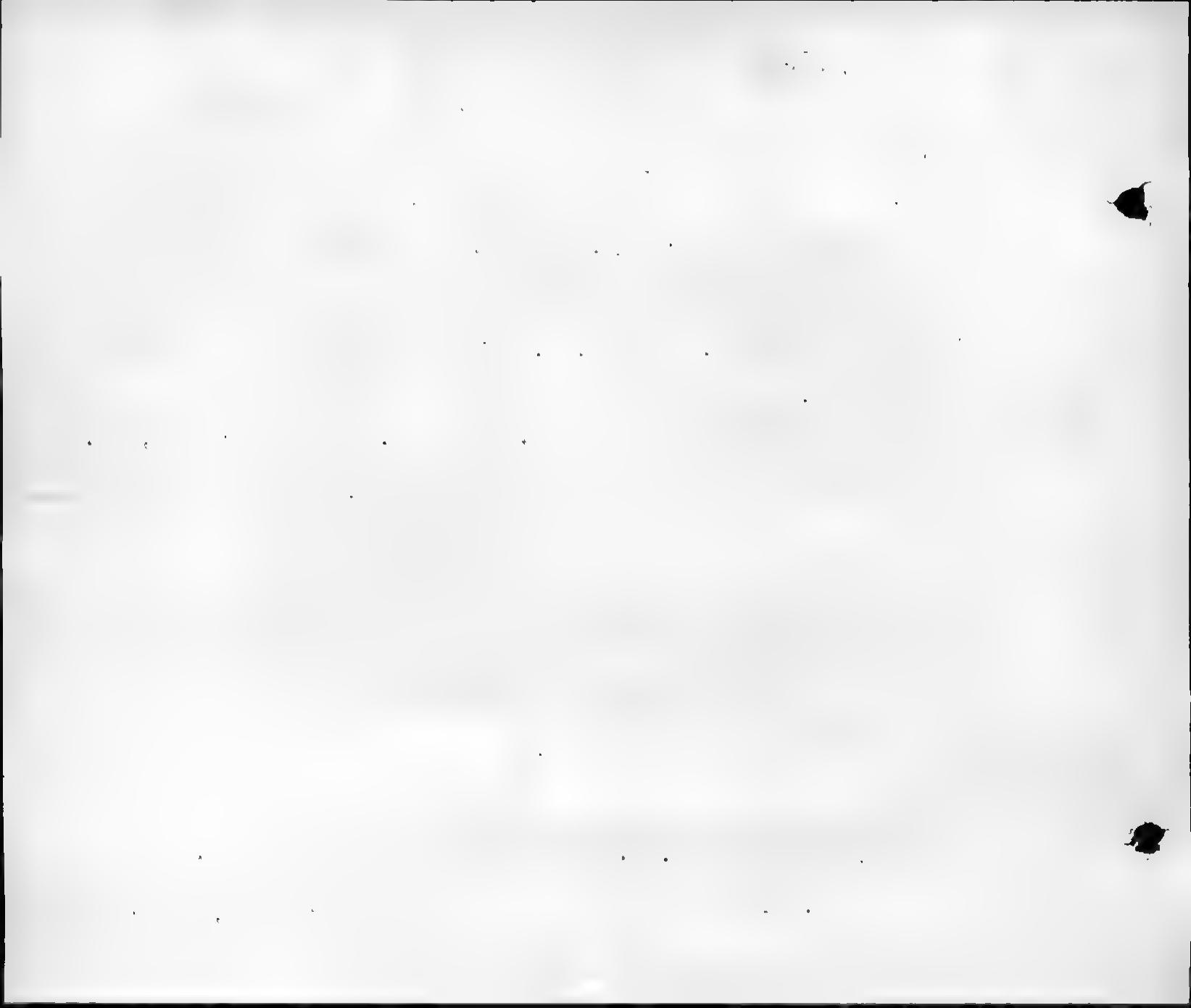
TO HOSPITAL
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11191

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 33 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1037 Spruce Street		d. STREET ADDRESS 1037 Spruce Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First James	Middle Franklin	Last Hart
4. DATE OF DEATH	Month January	Day 13	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5 1892
9. AGE (in years last birthday) 68 yrs	10. IF UNDER 1 YEAR Months 9	11. IF UNDER 24 HRS Days 7	12. IF UNDER 24 HRS Hours 11 Min 55
10a. US/JAL OCCUPATION (Give kind of work done during most of working life even if retired) Ret'd Car Inspector		10b. KIND OF BUSINESS OR INDUSTRY Western Md. R.R. Big Poole Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph M. Hart		14. MOTHER'S MAIDEN NAME Frances Keefer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 705 10 4770	
17. INFORMANT Mrs. Lillian M. Hart		18. ADDRESS 1037 Spruce Street Hagerstown, Md.	
19. MEDICAL CERTIFICATION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			
420 Conditions if any which gave rise to immediate cause (a), stating the under- lying cause last.			
DUE TO Bilateral bronchitis pneumonia. 2-4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
0 Degener. liver, heart & disease of heart and lungs. O BPH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 9 1961, to Jan 13 1961, that (I) (we) last saw the deceased alive on Jan 13 1961, and that death occurred at 10 P.M., from the causes and on the date stated above.			
22a. SIGNATURE Edward W. Ditto III,		22b. DATE 1/13/61	
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M. D.		22d. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
23a. BURIAL CREMATION Burial (Specify)		23b. DATE THEREOF Jan. 16, 1961	
23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION (City, town, or county) Hagerstown, Maryland (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Alfred L. Leaf Williamsport, Maryland		25a. REGD BY REGISTRAR JAN 17 1961	
ADDRESS		25b. REGISTRAR'S SIGNATURE L. Leaf	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1206

CERTIFICATE OF DEATH

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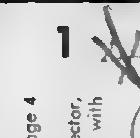
1 PLACE OF DEATH a. COUNTY WASHINGTON			2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. LENA - RURAL			c. LENGTH OF STAY IN 1b 4 MONTHS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BOONSBORO MD. R. I.			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND		
3. NAME OF DECEASED (Type or print) ESTIE FLORENCE HAUPT			d. STREET ADDRESS BELIVIEUR - RURAL		
3. NAME OF DECEASED (Type or print) ESTIE FLORENCE HAUPT		First ESTIE	Middle FLORENCE	4. DATE OF DEATH JANUARY 24 - 21 - 1961	Month Day Year
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> JUNE - 7 - 1867	9. AGE (In years last birthday) 93 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 7 Days 14 Hours 0 Min.
10a. USAL. OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE			10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
10c. BIRTHPLACE (State or foreign country) NEAR MIDDLETON FRED. Co MD USA			11. BIRTHPLACE (State or foreign country) NEAR MIDDLETON FRED. Co MD USA		
13. FATHER'S NAME THOMAS PALMER			14. MOTHER'S MAIDEN NAME SARAH MOSER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO 215-73-1775		
17. INFORMANT CLIFFORD E. HAUPT MIDDLETON MD R. I.			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Breast		
			INTERVAL BETWEEN ONSET AND DEATH 1 year		
			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) b. DUE TO Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause first.		
			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o. m 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10-1-60 to 1-24-61 , that (I) (we) last saw the deceased alive on 1-18-61 , and that death occurred at 10 P.M. from the causes and on the date stated above.			22b. DATE SIGNED		
22a. SIGNATURE J. E. W. DITT. J.			M. D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) J. E. W. DITT. J.			22d. ADDRESS Hagerstown Md.		
23a. BUR. AT. CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF JAN. 24, 1961		
23c. NAME OF CEMETERY OR CREMATORIUM LUTHERAN CEMETERY			23d. LOCATION (City, town, or county) MYERSVILLE FRED. Co MD.		
24. FUNERAL DIRECTOR'S SIGNATURE John H. Best			25a. ADDRESS Boonsboro MD		
			25b. REC'D BY REGISTRAR DATE JAN 26 '61		
			25c. REGISTRAR'S SIGNATURE John S. Kline		

TO HOSPITAL **ATTENDING PHYSICIAN** The law requires that the death certificate be executed within 24 hours after death. **Page 4**

TO THE ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-Transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59





MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1207

303

(1193)

1 PLACE OF DEATH a COUNTY "Washington		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 619 No Potowmack St		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 335 No Potowmack St						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) MAUDE		First MARY	Middle HAYMAN	Last HAYMAN	4. DATE OF DEATH January 10 1961 19	Month January	Day 10	Year 1961
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 17 1874		
9. AGE (In years last birthday) 86 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chiropractic Physician		10b. KIND OF BUSINESS OR INDUSTRY Lushore Sullivan Co Pa		11. BIRTHPLACE (State or foreign country) USA		
12. CITIZEN OF WHAT COUNTRY? USA								
13. FATHER'S NAME George W. Hayman		14. MOTHER'S MAIDEN NAME Catherine E. Hoffman						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Marjorie Hayman 337 No Potowmack St				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 332 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO Cerebral Thrombosis				Hagerstown Md		INTERVAL BETWEEN ONSET AND DEATH 6 days		
(b) DUE TO Generalized U. t. - disease						years		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(c)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour a. m. — p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.								
22a. SIGNATURE John Wilson, M.D.		M.D.		ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 1/11/61	
22c. PHYSICIAN'S NAME (Type) J. D. WILSON, M.D.		22d. ADDRESS 1 Hagerstown Md						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/13/61		23c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		23d. LOCATION (City, town, or county) Hagerstown Wash Co Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 13 '61		25b. REGISTRAR'S SIGNATURE C. M. S. T. 1961		

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be held by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. E.G. HOACHLANDER

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11194

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate lim's, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 19 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 211 FAIRGROUND AVENUE		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
3. NAME OF DECEASED (Type or print) MAUDE LEE HAYNES		d. STREET ADDRESS 211 FAIRGROUND AVENUE	
4. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	First F	Middle L	Last H
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 12 1895
9. AGE (In years last birthday) 65 yrs.	10. IF UNDER 1 YEAR 5 14	11. IF UNDER 24 HRS. Months Days Hours Min	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) BREMERTON WASH.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CALVIN BEETS		14. MOTHER'S MAIDEN NAME SARAH BRADEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MISS THELMA L. HAYNES HAGERSTOWN MD		18. ADDRESS 211 FAIRGROUND AVE HAGERSTOWN MD	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 512X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DEMO (c) DEMO			
Chronic glomerular nephritis years			
Arteriosclerosis; hypertension years			
Diabetes mellitus, obesity years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) Bilateral amyotrophy above Knees			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a m p m		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/16/61 to 1/23/61 , that (I) (we) last saw the deceased alive on 1/16/61 , and that death occurred at Hagerstown , from the causes and on the date stated above			
22a. SIGNATURE Eldon Hoachlander		22b. DATE SIGNED 1/28/61	
22c. PHYSICIAN'S NAME (Type) Eldon S. Hoachlander		22d. ADDRESS Hagerstown MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN 29 61	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Locust Grove Cemetery		23d. LOCATION (City, town or county) (State) Locust Grove WASH. Co. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John S. Best		25a. REC'D BY REGISTRAR DATE FEB 2 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Thrall			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1209

CERTIFICATE OF DEATH

303

(1195)

PLACE OF DEATH

o COUNTY

Washington

MARYLAND

2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)

o STATE

Maryland

b COUNTY

Washington

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

c LENGTH OF STAY IN 1b

D.O.A.

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Williamsport R # 1

d NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

Washington County Hospital

d STREET ADDRESS

Downsville Pike

e IS RESIDENCE ON A FARM?

YES

NO

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

CYNTHIA

MAE

HEBB

January

16 1961

19

5. SEX

6 COLOR OR RACE

7 MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
lost birthday)
yrs.

10. IF UNDER 1 YEAR IF UNDER 24 HRS

Female

White

WIDOWED DIVORCED

August 10 1960

Months

Days

Hours

Min

5 6

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Hagerstown Wash. ton Co

USA

13. FATHER'S NAME

Donald Hebb

14. MOTHER'S MAIDEN NAME

Nyoka Sciese

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes give war or date of service)

No

16. SOCIAL SECURITY NO

17. INFORMANT

Address

None

Donald Hebb Williamsport R # 1

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

921.0

DUE TO

Aspiration

Maryland

INTERVAL BETWEEN
ONSET AND DEATHConditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last

(b)

DUE TO

(c)

Vomitus

Immediate

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES

NO

20a. ACCIDENT WAS UNDERLYING CAUSE
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 1920d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home20f. (City or town)
Williamsport(County)
Wash(State)
Md.

21. I certify that (I) (this hospital) attended the deceased from 1/16/61 to 1/16/61, 1961, that (I) (we) last saw the deceased alive on 1/16/61, 1961, and that death occurred 3:30 AM from the causes and on the date stated above

22b. DATE
SIGNED22a. SIGNATURE
Ralph F. YoungM.D. ATTENDING PHYS MED DIRECTOR STAFF PHYS
22d. ADDRESS23a. BURIAL/CREMATION
REMOVED (Specify)

23b. DATE THEREOF

23d. LOCATION (City, town or county)

(State)

Burial

1/18/61

23c. NAME OF CEMETERY OR CREMATORI

Hagerstown Wash Co Md

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

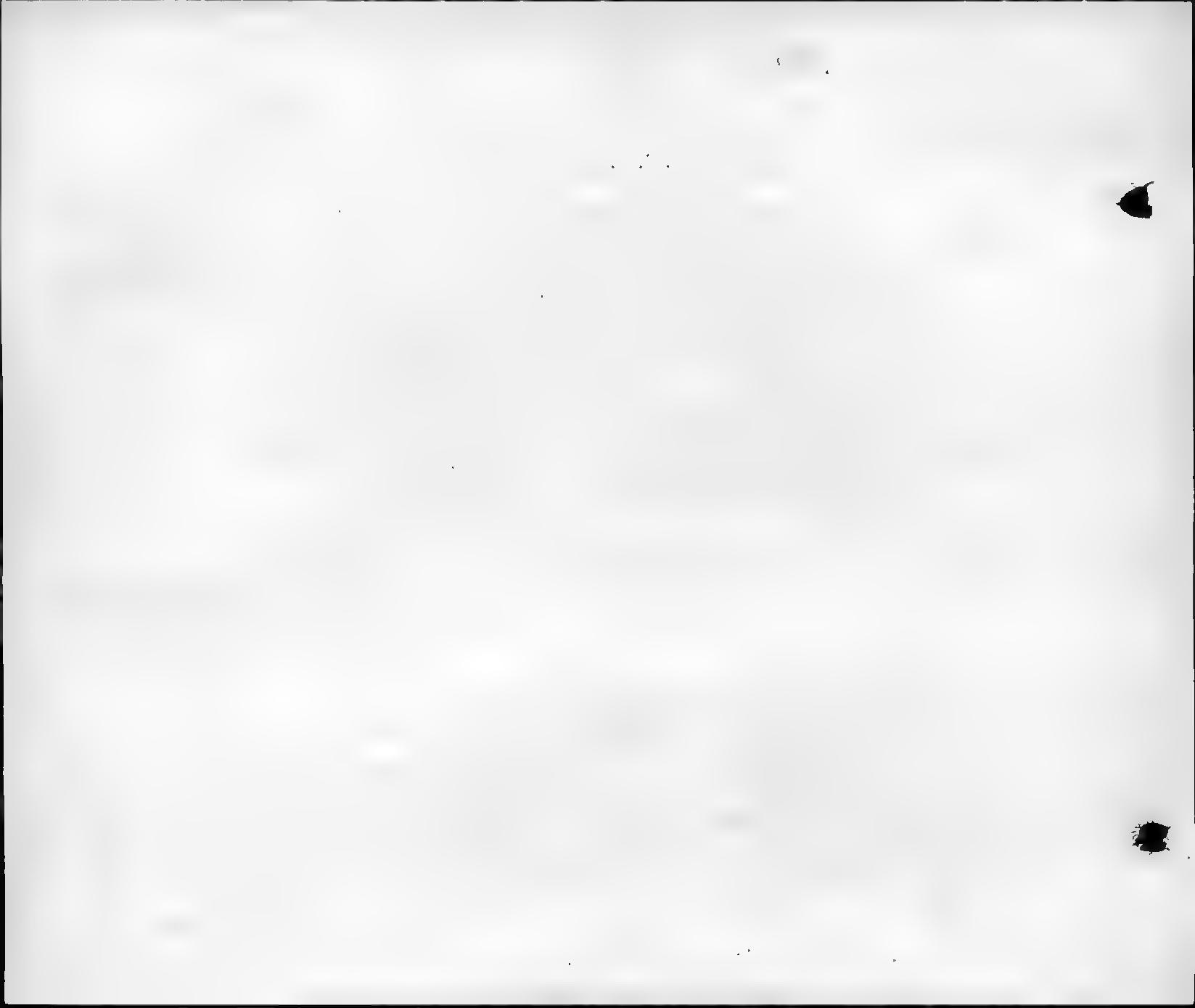
25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Andrew K. Coffman Hagerstown Md.

DATE JAN 19 '61

Clyne S. Hayes



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1210

CERTIFICATE OF DEATH

Reg. Dist. No. 1196

1. PLACE OF DEATH a. COUNTY WASHINGTON Co., MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE PA. b. COUNTY FRANKLIN				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ZELLINGER, PA.		c. LENGTH OF STAY IN lb 8 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS ZELLINGER, PA.				
3. NAME OF DECEASED (Type or print) IRENE ALICE HEINBAUGH		4. DATE OF DEATH 1 - 14 - 1961	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/4/1891			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) FULTON Co., Pa.			
13. FATHER'S NAME ABSLUM MELLOTT		14. MOTHER'S MAIDEN NAME AMANDA MELLOTT				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	17. INFORMANT Geo. S. Heinbaugh, Zellinger, Pa. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) KREMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. PyELONEPHRITIS (b) DUE TO (c) RENAL CALCULI		INTERVAL BETWEEN ONSET AND DEATH 1 MONTH 5 YRS 5 "				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —				
20c. TIME OF INJURY Hour o. g. p. m. 19	Month, Day, Year 1 - 14 - 1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County)	(State)
21. I certify that I attended the deceased from 1 - 6 - 1961 to 1 - 14 - 1961 that I last saw the deceased alive on 1 - 14 - 1961 , and that death occurred at 1 P.M. from the causes and on the date stated above.						
ACTUAL SIGNATURE J.G. Warden	PHYSICIAN'S NAME (Type) J.G. WARDEN, M.D.	ADDRESS (Street, city or town, state) 832 Potomac Ave. HAGERSTOWN, MD				DATE SIGNED
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/17/61	22c. NAME OF CEMETERY OR CREMATORIAL Union Cem.	22d. LOCATION (City, town, or county) McConnellsbury, PA. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE J.M. Grininger	ADDRESS MERCERSBURG, PA.	24a. REC'D BY REGISTRAR DATEIAN 23 '61		24b. REGISTRAR'S SIGNATURE Oleg S. Kraus		



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1211

CERTIFICATE OF DEATH

(119)

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) b. STATE	
WASHINGTON MARYLAND		MARYLAND WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
c. LENGTH OF STAY IN lb 35 YRS.		d. STREET ADDRESS 6 SNYDER AVE.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6 SNYDER AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First FLORENCE	Middle ETHELDIA
4. DATE OF DEATH		Lost HOFFMASTER	Month JANUARY
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
FEMALE		WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years lost birthday) 88 yrs.	
5/10/1872		IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN W. CLIPP		14. MOTHER'S MAIDEN NAME MARY HOFFMASTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown, If yes, give war or date of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MISS MARY HOFFMASTER		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUETO (c)	
		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
		General arterio sclerosis 16 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART 1(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-1-60 to 1-6-61, that (I) (we) last saw the deceased alive on 1-4-1961, and that death occurred at PM, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <i>John W. Clipp Jr.</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>John W. Clipp Jr.</i>		22d. ADDRESS <i>Hagerstown, Md.</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/9/61	
23c. NAME OF CEMETERY OR CREMATORIAL MT. VIEW CEM.		23d. LOCATION (City, town, or county) SHARPSBURG (State) MD.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Norment, Hagerstown, Md.</i>		25a. REC'D BY REGISTRAR DATE JAN 10 '61	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus.</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1212

CERTIFICATE OF DEATH

501
(i) 152

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 11 Wynwood Drive			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 Wynwood Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JOHN NEWTON HUFF		First	Middle	Last	4. DATE OF DEATH January 9, 1961	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 27, 1873	9. AGE (in years last birthday) 87	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Landis Tool Co Ringgold Wash Co Md		11. BIRTHPLACE (State or foreign country) Wash Co Md		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Huff				14. MOTHER'S MAIDEN NAME Mary Harne					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 173-03-0665		17. INFORMANT Mrs. Virgie E. Huff, 11 Wynwood Dr		Address Hagerstown, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) Part I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b)		Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 18 hours			
DUE TO (c)		Generalized Arterio-Sclerosis		10 yrs		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Smithsburg	(County) Md	(State)
21. I certify that (I) (this hospital) attended the deceased from		Dec 11 1960 to Jan 9 1961, that (I) (we) last saw the deceased alive on Jan 9 1961, and that death occurred at 8 A.M. from the causes and on the date stated above.							
22a. SIGNATURE G. H. Kohler		22b. DATE SIGNED 1/10/61							
22c. PHYSICIAN'S NAME (Type) G. H. Kohler		22d. ADDRESS Smithsburg Md							
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE THEREOF 1/11/61		23c. NAME OF CEMETERY OR CEMATORIY Lutheran Cemetery		23d. LOCATION (City, town, or county) Leitersburg Wash Co Md			
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 13 '61		25b. REGISTRAR'S SIGNATURE C. C. L. Tamm			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be recorded by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1-24-61 File 279

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1213

1193

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 35 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
3. NAME OF DECEASED (Type or print) LORETTA		First MIDDLE FLORENCE	4. DATE OF DEATH JANUARY 19 1961
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/20/1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	9. AGE (In years lost birthday) 88 yrs
13. FATHER'S NAME JAMES M. WALLS		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE	17. INFORMANT MR. SYLVESTER HUNT
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 103.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		Bilateral lobar pneumonia Interstitial tissue fibrosis of left lung Pneumonia	
DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) general arteriosclerosis and arteriosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) Patient fell in bedroom — while up walking about	
20c. TIME OF INJURY 6:40 a.m.	Month, Day, Year 1 9 1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Hagerstown		(County) Wash.	
(State) Md.			
21. I certify that (I) (this hospital) attended the deceased from 11/21/58 to Jan 19, 1961, that (I) (we) last saw the deceased alive on Jan 18, 1961, and that death occurred at 3:30 P.M. from the causes and on the date stated above		22b. DATE SIGNED 1/24/61	
22a. SIGNATURE Edward W. Ditto III		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1/24/61
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M. D.		22d. ADDRESS 217 West Washington St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1/21/61	23c. NAME OF CEMETERY OR CREMATORIAL ORBISONIA CEM.	23d. LOCATION (City, town, or county) ORBISONIA, PENNA.
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Horment, Hagerstown Md.	ADDRESS	25a. REC'D BY REGISTRAR JAN 23 '61	25b. REGISTRAR'S SIGNATURE W. J. Horment



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

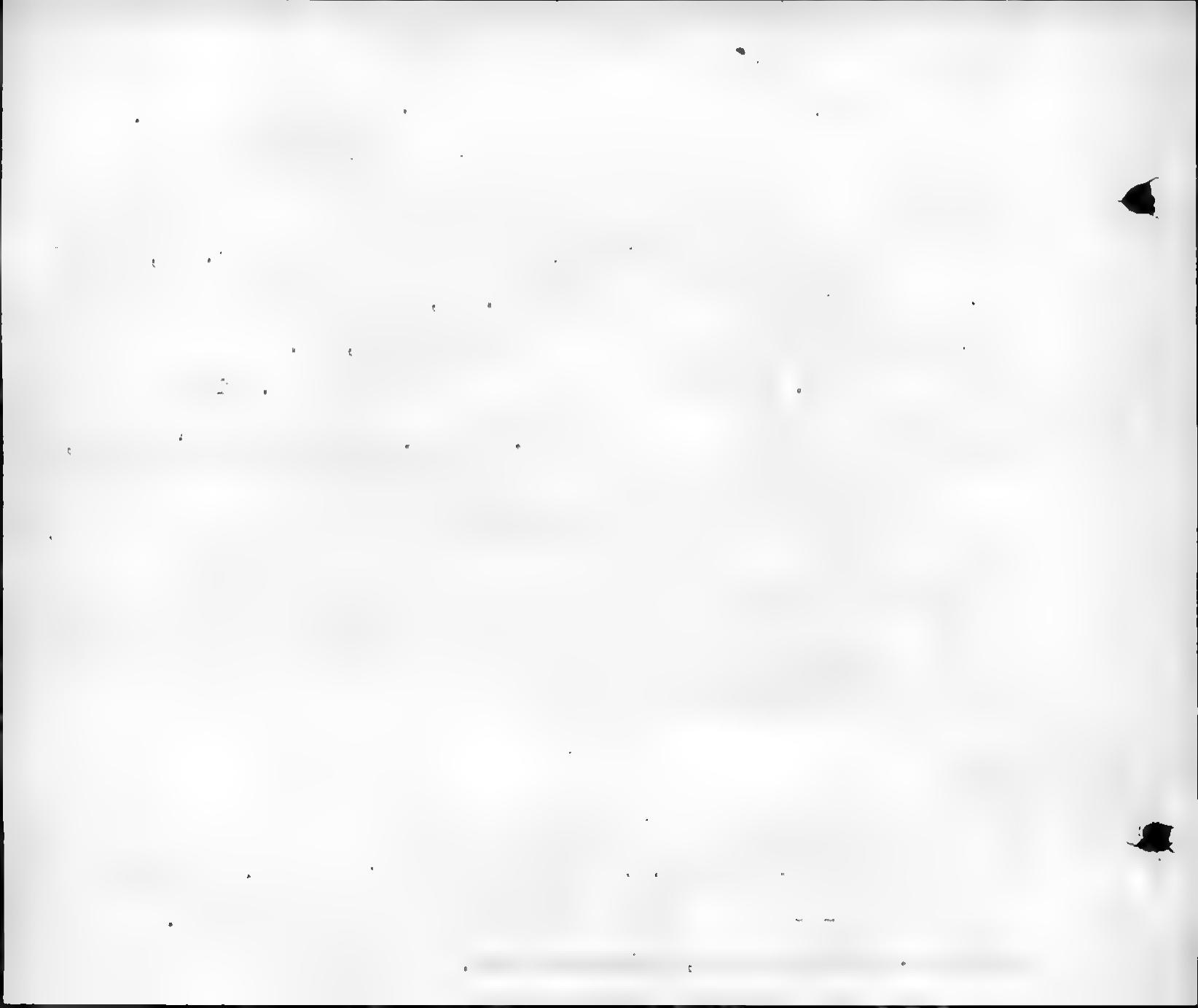
1214

CERTIFICATE OF DEATH

Reg. Dist. No.

(1260)

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Washington MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		b. COUNTY Wash.	
c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS RFD 2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Charles	Middle Calvin	Last Huntzberry
4. DATE OF DEATH	Month Jan.	Day 6,	Year 1961
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17, 1886
9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
13. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) truck farming	10b. KIND OF BUSINESS OR INDUSTRY farm	11. BIRTHPLACE (State or foreign country) Pondsville, Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John W. Huntzberry		14. MOTHER'S MAIDEN NAME Mary E. Diamond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO none	INFORMANT Mrs. Onie E. Huntzberry, Smithsburg, Md	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 10 Min.	
Coronary Occlusion			
4-20. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO Arteriosclerotic Cardiovascular Disease 3 Yrs.	
(b). DUE TO			
(c). DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-2-1961 to 1/5-1961, that I last saw the deceased alive on 1/5-1961, and that death occurred at 3:24 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. Hess		ADDRESS (Street, city or town, state) Smithsburg, Md.	
PHYSICIAN'S NAME (Type) Charles F. Hess M.D.		DATE SIGNED 1/5/61	
22a. BURIAL, CREMATION REMOVAL (Specify) burial		22b. DATE THEREOF 1-9-61	
22c. NAME OF CEMETERY OR CREMATORIUM Smithsburg Cemetery		22d. LOCATION (City, town, or county) Smithsburg, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR JAN 9 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Charles S. Hess	



1 TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

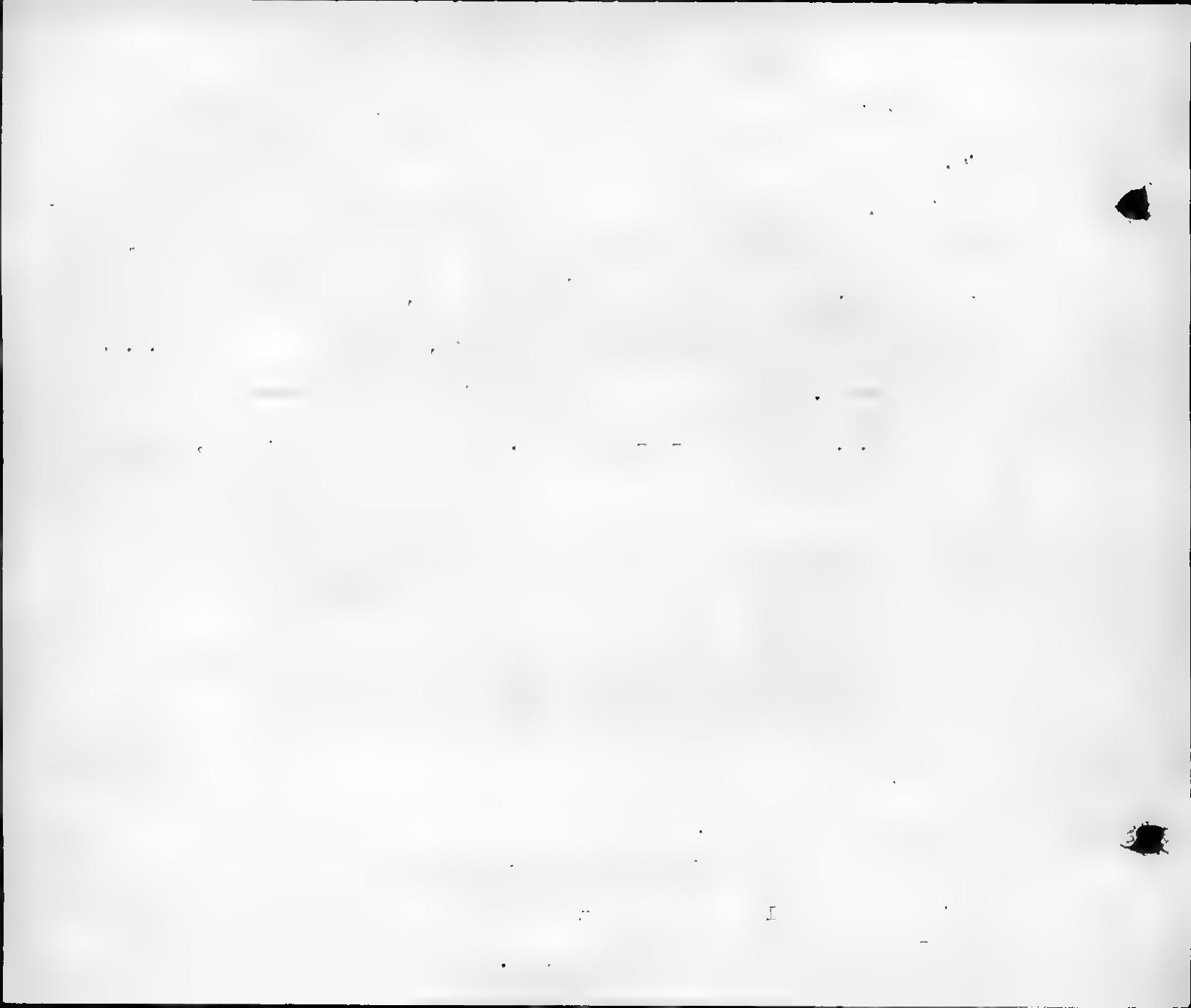
3 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1215

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 26 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) DAVID		First COLSON	Middle HURST
4. DATE OF DEATH January		Month	Day 1 Year 1961
5. SEX Male 6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 4, 1896
9. AGE (In years from birthday) 84 yrs		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min. 0
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Foundry Company	
11. BIRTHPLACE (State or foreign country) Harlan, Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John B. Hurst		14. MOTHER'S MAIDEN NAME Missouri Belle Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-09-2934	
17. INFORMANT Mrs. Janet Charles		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Azotemic DUE TO 260X Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arterio to the Phrenclerain DUE TO (c) Diabetes Mellitus	
		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Emphysema		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown (County) Maryland (State) Md.	
21. I certify that (I) (the hospital) attended the deceased from Dec. 26, 1960 , to Jan 1, 1961 , that (I) last saw the deceased alive on Jan 1, 1961 , and that death occurred at 12 AM , from the causes and on the date stated above.		22a. SIGNATURE David C. Hoffman	
22c. PHYSICIAN'S NAME (Type) David C. Hoffman		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 214 N. Potomac St	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/3/1961	
23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION (City, town, or county) Hagerstown (State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Houzer Funeral Home <i>R. Franklin Suter</i>		25a. REC'D BY REG. STRR. DATE JAN 4 1961	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kress</i>	

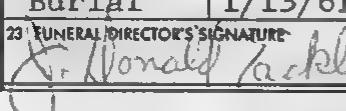


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1216

CERTIFICATE OF DEATH

Reg. Dist. No. 11262

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Hook		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Hook	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence		d. STREET ADDRESS Main Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First NELLIE	Middle VENDILLA	Last JOHNSON
4. DATE OF DEATH	January 11, 1961	Month	Day
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1879
9. AGE (In years last birthday) 81	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. BIRTHPLACE (State or Foreign country) Shepherdstown, West Va.
13. FATHER'S NAME Griffith Taylor	14. MOTHER'S MAIDEN NAME Elva Madora Buffington	12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, give war or date of service) No None	16. SOCIAL SECURITY NO. None	17. INFORMANT Miss Margaret Buffington RFD# 1, Knoxville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OR 88 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Senility 5 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-8-1961 to 1-11-1961, that I last saw the deceased alive on 1-11-1961, and that death occurred at 9:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brunswick, Md.			
ACTUAL SIGNATURE 	M.D.	DATE SIGNED 1-12-61	
PHYSICIAN'S NAME (Type) C. E. Pruitt, M.D.	Brunswick, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/13/61	22c. NAME OF CEMETERY OR CREMATORIAL Brethren Cemetery	22d. LOCATION (City, town, or county) (State) Brownsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE 	ADDRESS Harpers Ferry, W. Va.	24a. REC'D BY REGISTRAR DATE JAN 13 '61	24b. REGISTRAR'S SIGNATURE 

TO HOSPITAL: _____ by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

(1263)

1217

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dargan		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Charles Johnson Residence		e. STREET ADDRESS	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First VIOLA	Middle BELLE	Last JOHNSON
4. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> May 19, 1877	9. AGE (In years last birthday) 85 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Mountain Lock, Maryland USA	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Franklin Randolph Zimmerman	14. MOTHER'S MAIDEN NAME Margaret Amelia Roulette		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mr. Charles Johnson RFD# 1, Harpers Ferry, West Va.	18. INTERVAL BETWEEN ONSET AND DEATH 302 weeks
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		DUE TO Cerebral vascular accident Hypertension, cardiovascular disease, 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 6-1-1969 to 1-27-1969	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from 6-1-1969 to 1-27-1969 , that (I) (we) last saw the deceased alive on 6-1-1969 , and that death occurred at 2:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Franklin Zimmerman Jr.		22b. DATE SIGNED 1-27-69	
22c. PHYSICIAN'S NAME (Type) Hiram Zimmerman Jr.		22d. ADDRESS Stephensburg, W. Va.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 1/30/61	23c. NAME OF CEMETERY OR CREMATORIUM Samples Manor Cemetery	23d. LOCATION (City, town, or county) (State) Samples Manor, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Ronald E. Eakle		25a. ADDRESS Harpers Ferry, W. Va.	25b. REGISTRAR'S SIGNATURE C. Alvin E. Eakle
		DATE JAN 31 '61	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

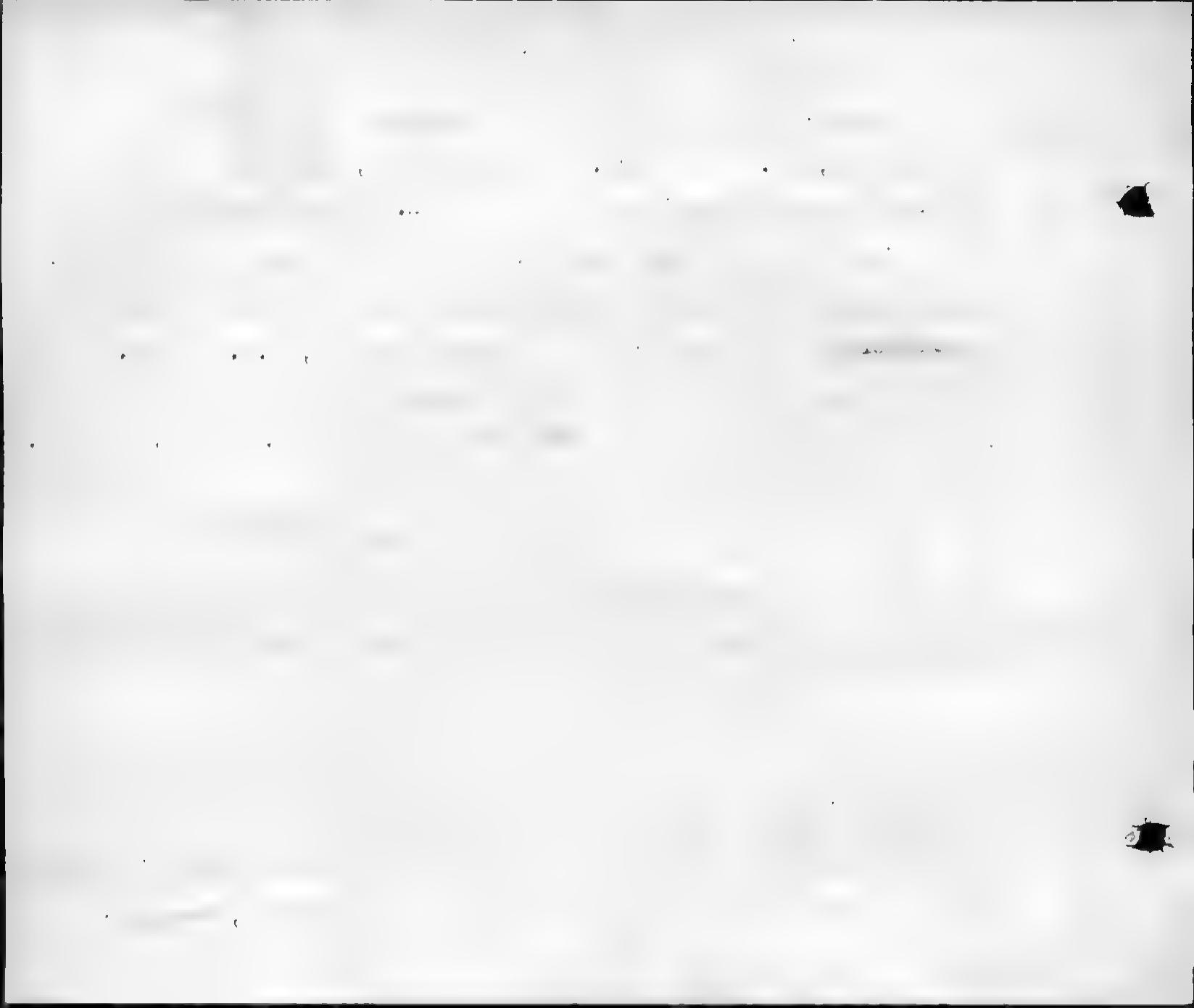
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1218

(1218)

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) <input checked="" type="checkbox"/> INSTITUTION <input type="checkbox"/> RESIDENCE before admission a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.		c. LENGTH OF STAY IN 1b 9 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland		d. STREET ADDRESS 315 N. Potomac Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Charles		First	Middle	Last	4. DATE OF DEATH Jan 14	Month	Day	Year 1961
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 31 1887	9. AGE (in years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of work not life even if retired) Chiropractor		10b. KIND OF BUSINESS OR INDUSTRY Chiropractor		11. BIRTHPLACE (State or foreign country) British Guiana, S.A.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Henry Jones		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 214-36-0031		17. INFORMANT Evelyn Clark		Address 68 W. 44th St. Bayonne N.J.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 49		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 7 days		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b)		arteriosclerotic heart disease (omas)				
		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County) Maryland
21. I certify that (I) (this hospital) attended the deceased from 11-26-60 to 1-14-61 , 19____, that (I) (we) last saw the deceased alive on 1-14-61 , 19____, and that death occurred at 8:30 P , from the causes and on the date stated above.								(State)
22a. SIGNATURE Searl Young		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) SEARL YOUNG MD		22d. ADDRESS 448 N. Potomac St, Hagerstown, Md.						
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 17 1961		23c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		23d. LOCATION (City, town, or county) Hagerstown, Maryland		(State)
24. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr Hagerstown, Md.		ADDRESS		25a. REC'D BY REG STAR Curtis L. Hause		25b. REGISTRAR'S SIGNATURE Curtis L. Hause		
				DATE JAN 23 '61				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

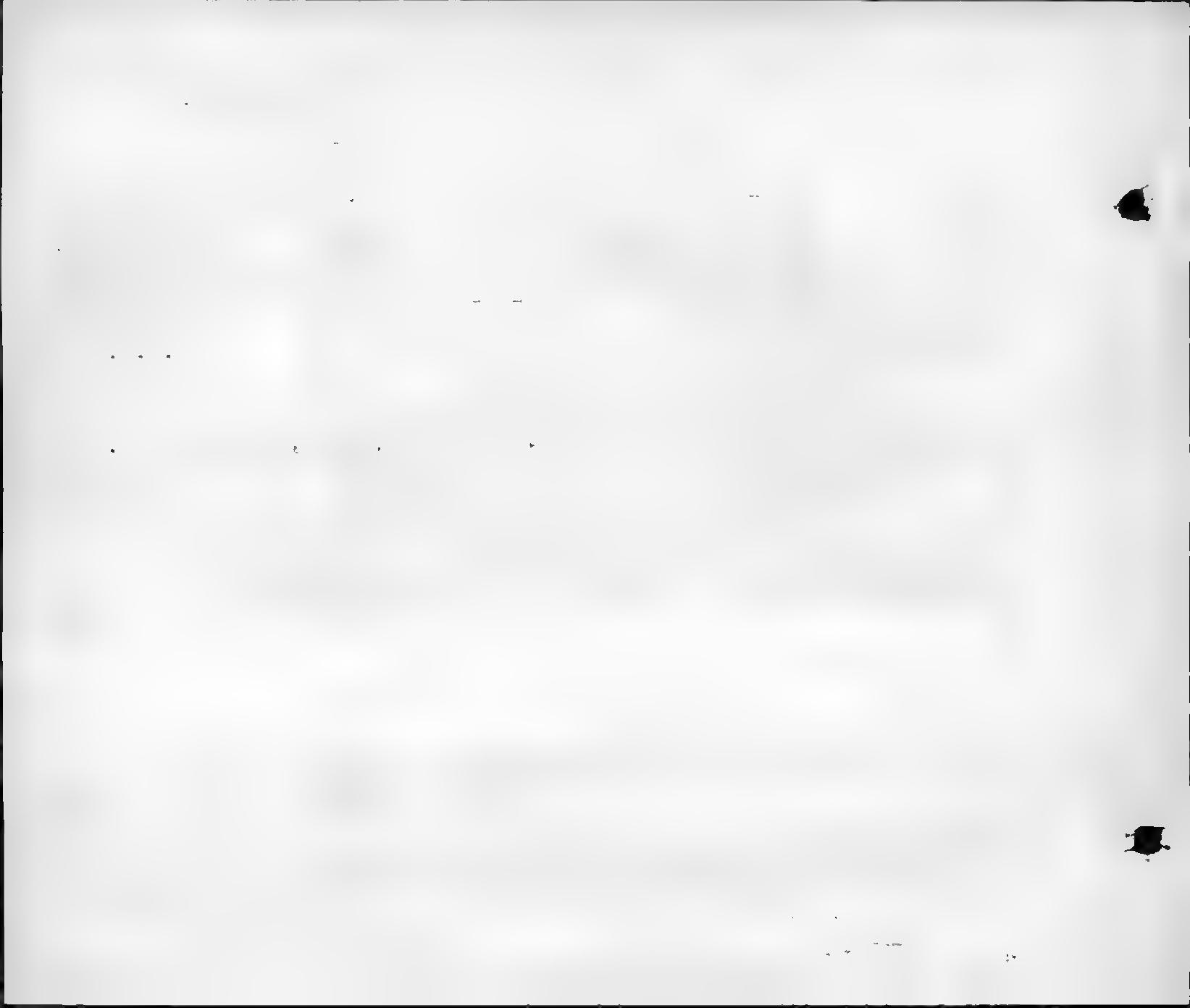
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 11-27-61 et
1219

CERTIFICATE OF DEATH

Reg. Dist. No. (1265)

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Knoxville		d. STREET ADDRESS —	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mary Edwina Jones		First	Middle	Last	4. DATE OF DEATH 1 17 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6-22-1895	9. AGE (In years last birthday) 65 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or Foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John Minn		
14. MOTHER'S MAIDEN NAME Sally Leach			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no, or unknown) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Mr. Everett T. Jones, Knoxville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) X DUE TO Pulmonary Tuberculosis			INTERVAL BETWEEN ONSET AND DEATH Years		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Glossitis & nephritis - Diabetic mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boonsboro, Md.	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ 1-9-1961 to 1-17-1961, that I last saw the deceased alive on 1-17-1961, and that death occurred at 11:30 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Hewitt			ADDRESS (Street, city or town, state) M.D. 21 North Main St. DATE SIGNED 1/17/61		
PHYSICIAN'S NAME (Type) Joseph Secondari			Boonsboro, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-20-1961	22c. NAME OF CEMETERY OR CREMATORIAL Brethren	22d. LOCATION (City, town, or county) Brownsville, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE H. G. Fife			24a. REC'D BY REGISTRAR DATE JAN 23 '61	24b. REGISTRAR'S SIGNATURE Charles S. Knott	
ADDRESS Brunswick, Maryland					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1220

CERTIFICATE OF DEATH

61206

1. PLACE OF DEATH
a. COUNTY

WASHINGTON

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

HAGERSTOWN

MARYLAND

c. LENGTH OF STAY IN 1b

LIFE

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

1713 PENNSYLVANIA AVENUE

3. NAME OF
DECEASED
(Type or print)

MARIA GERTRUDE

First

Middle

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

b. STATE

MARYLAND

b. COUNTY

WASHINGTON

c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

HAGERSTOWN

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED NEVER MARRIED DIVORCED

KEEDY

8. DATE
OF
BIRTH

MAY 21 1871

Last

4. DATE
OF
DEATH

JAN.

24

1961

Month

Day

Year

9. AGE (in years
last birthday) IF UNDER 1 YEAR
Months Days

89 yrs.

F UNDER 24 HRS.
Hours Min10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOMEMAKER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

WASHINGTON MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

DANIEL BAKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.

(Yes, no, or unknown) (If yes, give rank or dates of service)

NO

17. INFORMANT

Address

MARY ANNA HOOVER

CATHERINE BAKER HAGERSTOWN MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)221X
Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last

DUE TO

(b)

DUE TO

(c)

Cerebral hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

3 days

Generalized arteriosclerosis x

Year

by hypertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

20d. INJURY OCCURRED

While at work

Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

19

21. I certify that (I) (this hospital) attended the deceased from 1-21

1961, to 1-21

1961, that (I) (we) last

saw the deceased alive on 1-21 1961, and that death occurred at 12:00 A.M. from the causes and on the date stated above.

22e. SIGNATURE

22f. ATTENDING PHYS. M.D.

22b. DATE SIGNED

22d. MED. DIRECTOR

STAFF PHYS.

1-25-61

22d. ADDRESS

23a. BURIAL, CREMATION DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION (City, town or county)

(State)

REMOVAL (Specify)

BURIAL 1/26/61

ROSE HILL CEMETERY

HAGERSTOWN

MARYLAND

24. FUNERAL DIRECTOR OR FUNERAL HOME

ADDRESS

25a. REC'D. BY REGISTRAR

(State)

Charles M. Fouzer

HAGERSTOWN MARYLAND

FEB 2 1961

61

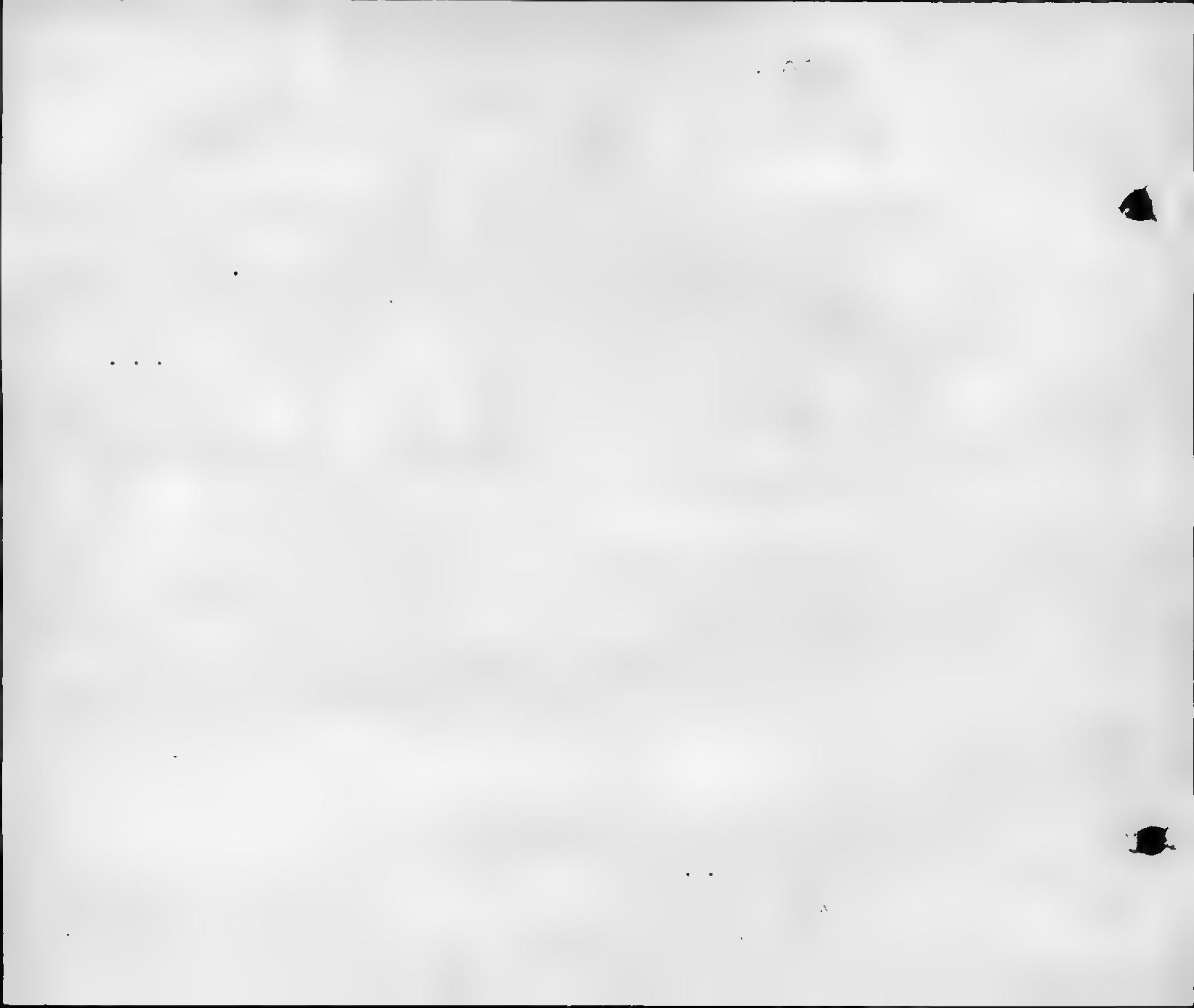
25b. REG. STRR'S SIGNATURE

Arthur S. French

DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

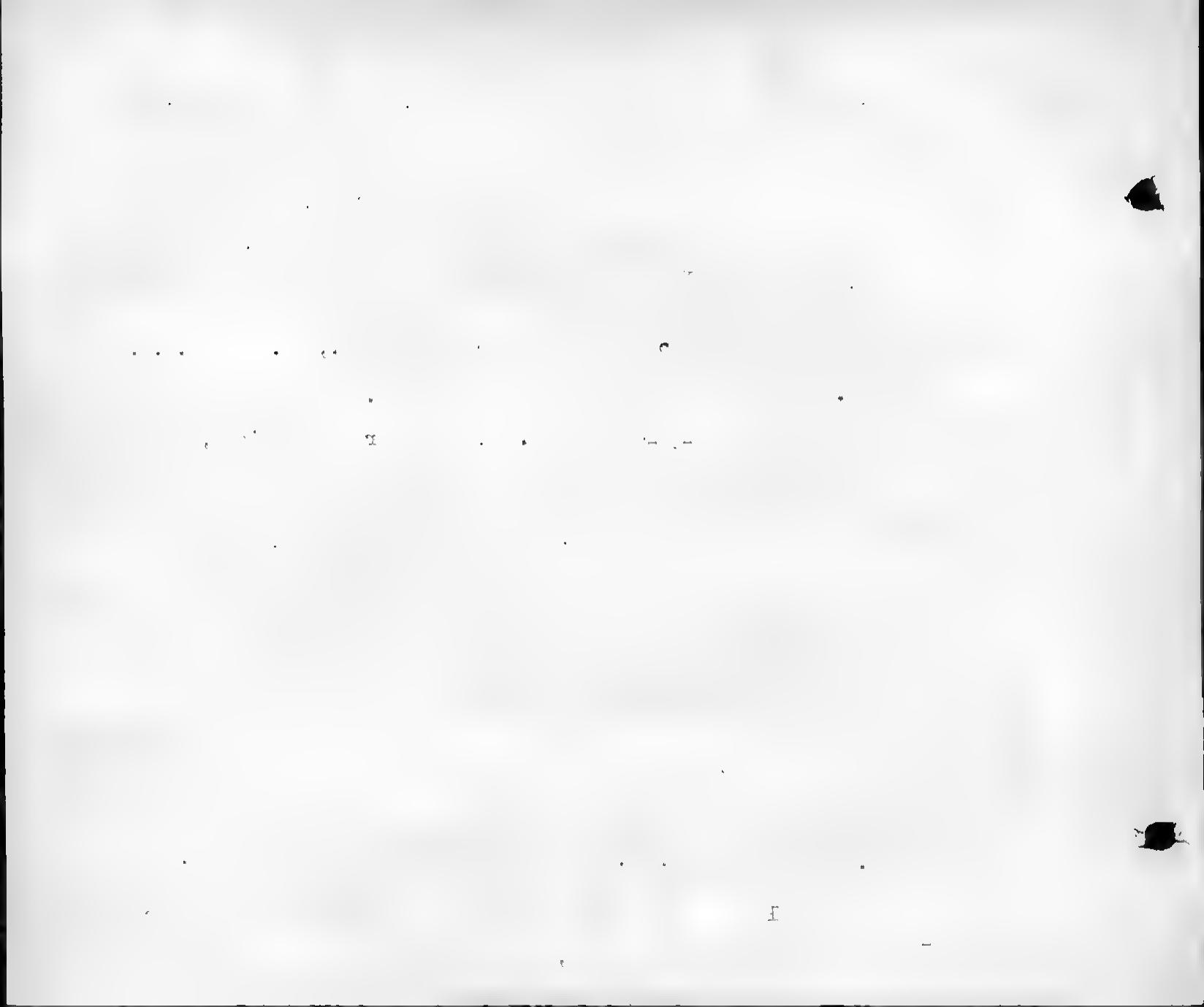


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1267

1. PLACE OF DEATH o COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE MARYLAND	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c LENGTH OF STAY IN 1b most of life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 834 Concord Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) ARTHUR		First DANIEL	Middle KELLER
4. DATE OF DEATH January		Month 4	Day 161
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH February 21, 1900		9. AGE (In years last birthday) 60	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Helper		10b. KIND OF BUSINESS OR INDUSTRY Railroad	10c. BIRTHPLACE (State or foreign country) Washington Co., Md.
11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. MOTHER'S MAIDEN NAME Alice M. Baker	
13. FATHER'S NAME Hammer C. Keller		14. MOTHER'S MAIDEN NAME Alice M. Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-10-4601	17. INFORMANT Mrs. Ellen Kelley
		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0		INTERVAL BETWEEN ONSET AND DEATH Terminal	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Due to (c)		<i>Myocardial Infarction</i> <i>Post-embolic Heart Disease</i> 5 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 4, 1961 to Jan 4, 1961 , that (I) (we) last saw the deceased alive on Jan 4, 1961 , and that death occurred at 12:00 P.M. from the causes and on the date stated above		22b. DATE SIGNED Jan 4, 1961	
22a. SIGNATURE Edward W. Ditto, M.D.		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. ADDRESS 217 West Washington St.
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M. D.		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 1/7/1961	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home		ADDRESS Hagerstown, Maryland	25a. REC'D BY REGISTRAR JAN 6 '61
			25b. REGISTRAR'S SIGNATURE Orville S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1222 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. (1218)

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghmanton		d. STREET ADDRESS Tilghmanton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Western Md. State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Elizabeth Rosina Kemp		First	Middle	Last	4. DATE OF DEATH Jan. 29, 1961	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 1 1871		9. AGE (In years last birthday) 89 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Sharpsburg Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John William Fisher				14. MOTHER'S MAIDEN NAME Helen Himes					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. Nevin Barnhart Tilghmanton Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lobular pneumonia</i> INTERVAL BETWEEN ONSET AND DEATH 7 days 491 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>(b)</i> DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>① generalized arteriosclerosis ② Fracture rt. hip</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell while at home</i>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Fairplay, Washington, Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <i>J. E. D. D. T.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/29/61							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 1-61		22c. NAME OF CEMETERY OR CREMATORIUM Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Albert L. Leaf Williamsport, Md.</i>				ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 1 '61		24b. REGISTRAR'S SIGNATURE <i>Charles S. Krause</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY: **DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation or removal.

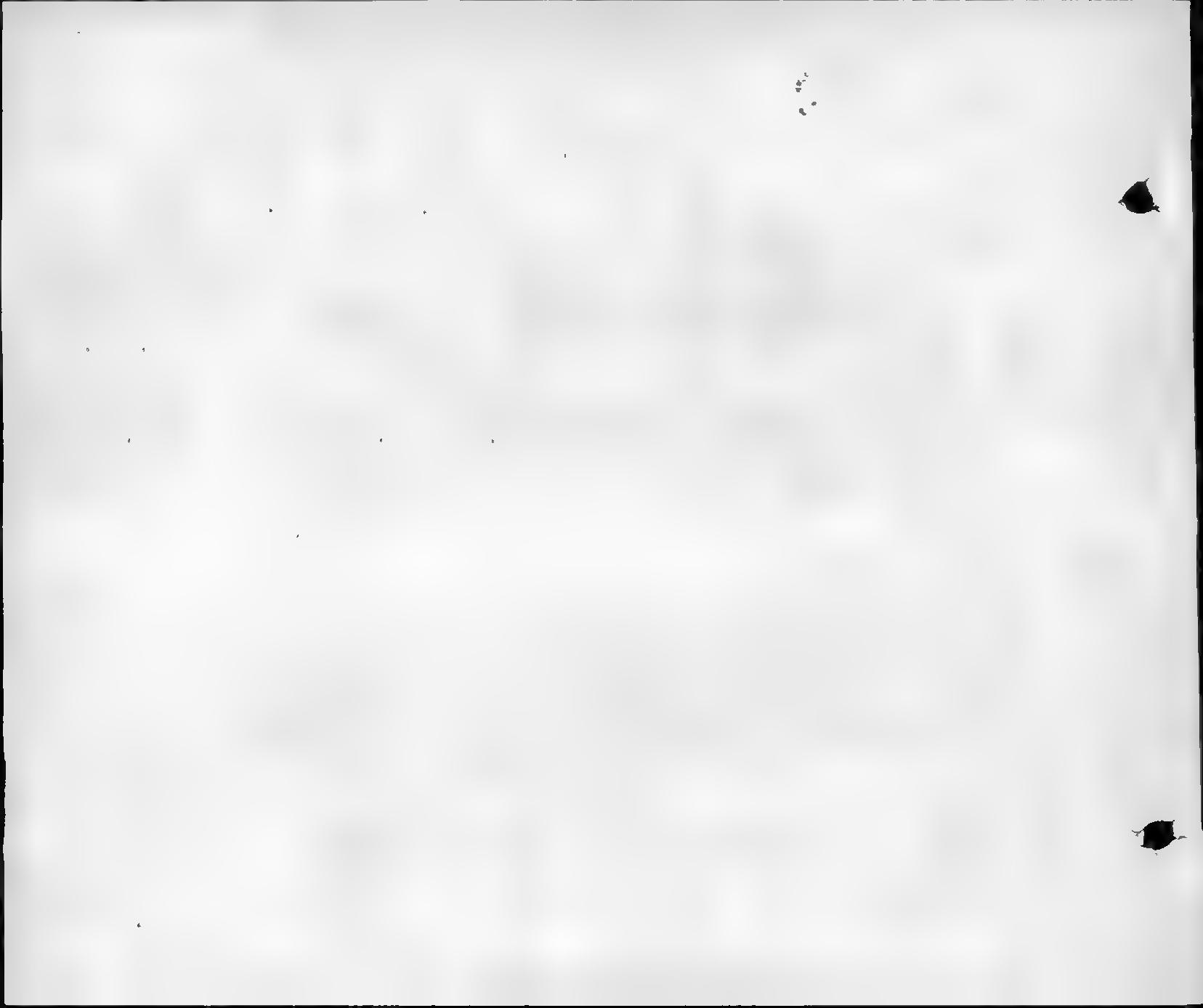
VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1223 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 1219

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MARYLAND	
WASHINGTON MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 60 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 716 S. LOCUST ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First RAYMOND	Middle EUGENE	Last KLINE
4. DATE OF DEATH	Month JANUARY	Day 24	Year 61 19
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2/5/1891
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FORLMAN	SILK MILL	VIRGINIA	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME MARY ?		
BUD KLINE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address HAGERSTOWN MD.
NO	214-09-3165	MRS. ANNA A. KLINE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
420 DUE TO Reute Rupture of myocardial infarction -			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO Cerebral atherosclerosis, Severe			
DUE TO 2-4 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE	Edward W. Ditto III		
EXAMINER'S NAME (Type)	Edward W. Dito III, MD DEPUTY MEDICAL EXAMINER		
DATE SIGNED 1/20/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/27/61	22c. NAME OF CEMETERY OR CREMATORIAL ROSE HILL CEM.	22d. LOCATION (City, town, or county) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Kornmeier Hagerstown, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 30 '61	24b. REGISTRAR'S SIGNATURE C. J. Smith



ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be retained by the physician or attending physician an.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

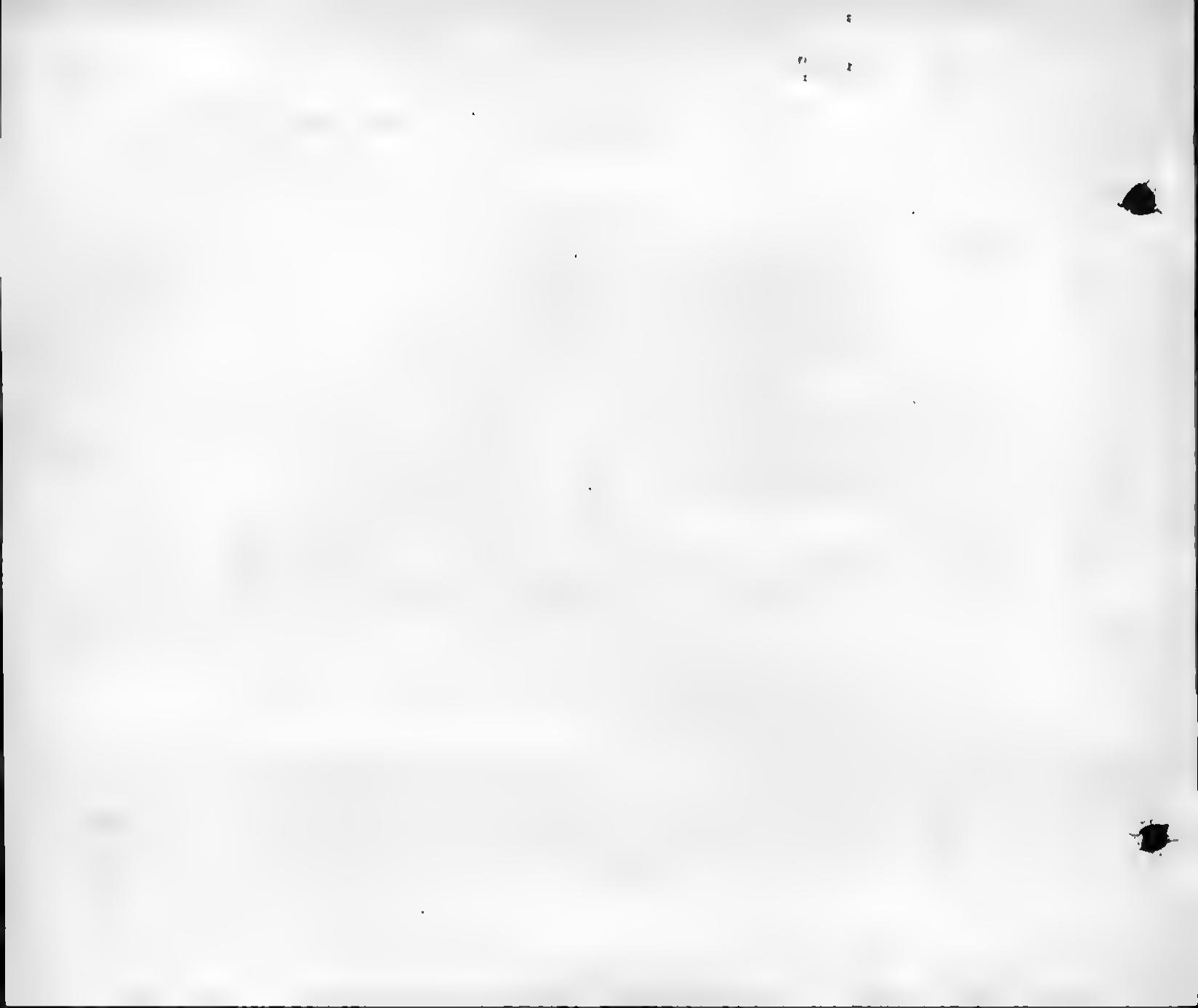
M
1224
DIT: LEVAN

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

61210

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND		b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRFAXTOWN		c. LENGTH OF STAY IN 1b ONE WEEK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BENEVOLA — RURAL		d. STREET ADDRESS BONNSBRO MD. 121	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. CO. HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First STANLEY	Middle P. F.	Last KLINE	4. DATE OF DEATH	Month JANUARY	Day 9	Year 1961
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 2, 1818	9. AGE (in years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months 4	11. IF UNDER 24 HRS Days 7	12. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILL OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY KLINE Bros. Inc.		11. BIRTHPLACE (State or foreign country) BENEVOLA WASH. CO MD. (US)		12. CITIZEN OF WHAT COUNTRY? Address	
13. FATHER'S NAME CHARLES KLINE		14. MOTHER'S MAIDEN NAME LYDIA STAHIRNEY					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Not, no or unknown. If yes, give war or dates of serv ce) NO		16. SOCIAL SECURITY NO. 213-01-1130		17. INFORMANT 17200 MARYTY RD. C. EDWIN KLINE		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-10 DUE TO Generalized arteriosclerosis Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause (b). (b) DUE TO Embolus to the lung (c) Reactions of prostate	
						INTERVAL BETWEEN ONSET AND DEATH 8 days	
19. WAS A JUDGMENT PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 13</u> , 1961, to <u>JAN 19</u> , 1961, that (I) (we) last saw the deceased alive on <u>JAN 8</u> , 1961, and that death occurred at <u>M.</u> from the causes and on the date stated above.							
22a. SIGNATURE G. W. Kline		M. D. ATTENDING PHYS		MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 1/10/61	
22c. PHYSICIAN'S NAME (Type) G. W. Kline		22d. ADDRESS 17200 MARYTY RD.					
23a. BURIAL CREMATION REMOVAL (Specify) ENTOMBMENT		23b. DATE THEREOF JAN 11, 1961		23c. NAME OF CEMETERY OR CREMATORIUM BONNSBRO MARYTY UNI		23d. LOCATION (City, town, or county) BONNSBRO WASH. CO. MD. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE J. H. Bart		ADDRESS BONNSBRO 1410		25a. REC'D BY REGISTRAR DATE JAN 16 '61		25b. REGISTRAR'S SIGNATURE G. W. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If it is not, it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1225

CERTIFICATE OF DEATH

1221

1. PLACE OF DEATH
a. COUNTY

Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

206 East Avenue

3. NAME OF
DECEASED
(Type or print)

First
MARY

MARYLAND

c. LENGTH OF STAY IN HB

Life

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

December 16, 1898

206 East Avenue

Last

4. DATE
OF
DEATH

January

Month

4

Dey

1961

Year

10a. USUAL OCCUPAT. ON (Give kind of work done during most of working life, even if retired)

Seamstress

10b. KIND OF BUSINESS OR INDUSTRY

Laundry

11. BIRTHPLACE (County & State, or foreign country)

Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jacob Sayles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of service)

no

16. SOCIAL SECURITY NO., 17. INFORMANT

214-09-4670 Mrs. Harold Lefferts

Address

Hagerstown, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
(IMMEDIATE CAUSE (a))

Cerebral Hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

1 day

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 3 Jan 1961, to 4 Jan 1961, that (I) (we) last saw the deceased alive on 11 Jan 1961, and that death occurred at 1150 AM, from the causes and on the date stated above.

22a. SIGNATURE

22c PHYSICIAN'S
NAME (Type)

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED

4 Jan 61

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

1/7/1961

23c. NAME OF CEMETERY OR CREMATORI

Rose Hill Cemetery

23d. LOCATION (City, town or county)

Hagerstown

(State)
Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Suter - Rouzer Funeral Home

P. Franklin Berger

ADDRESS

Hagerstown

25a. REC'D BY REGISTRAR

JAN 6 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Thomas



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

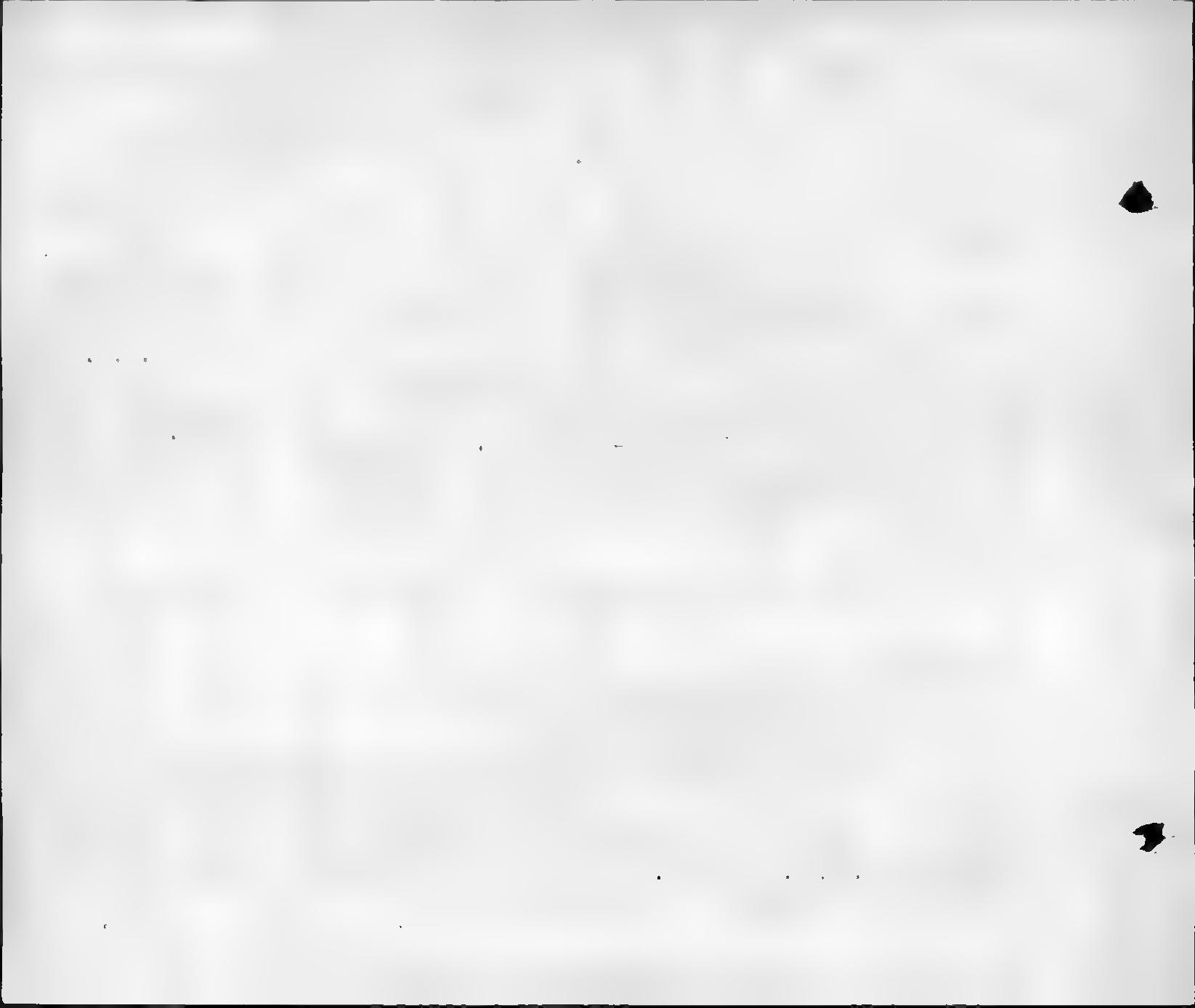
1226

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb 35 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARION	Middle SAMUEL	4. DATE OF DEATH JANUARY 22 1961
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR		10b. KIND OF BUSINESS OR INDUSTRY CHEMICAL MFG CO.	
10c. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JACOB LAYMAN		14. MOTHER'S MAIDEN NAME BIRTTIE MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-4130	
17. INFORMANT MRS. DAISY LAYMAN		Address LEWISTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerosis, Severe DUE TO Conditions, if any, which give rise to immediate cause (a), stating the underlying cause lost. 522X (b) Cardiac Hypertrophy DUE TO (c) Pulmonary Congestion and Edema			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) LEWISTOWN CHURCH CEM.
20f. (City or town) LEWISTOWN		(County) MD.	
(State) MD.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> J. W. Ditto, Jr.			
ACTUAL SIGNATURE J. W. Ditto, Jr.		DATE SIGNED 1-23-61	
EXAMINER'S NAME (Type) Dr. J. W. Ditto, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/25/61	
22c. NAME OF CEMETERY OR CREMATORIAL LEWISTOWN CHURCH CEM.		22d. LOCATION (City, town, or county) LEWISTOWN	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.		24a. ADDRESS ADDRESS	
24b. REC'D BY REGISTRAR DATE JAN 26 '61		24c. REGISTRAR'S SIGNATURE John S. Frame	

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55



TO HOSPITAL
may be rendered by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1227 14213

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) RURAL and give nearest town, B. T. W.		c. LENGTH OF STAY IN 1b Post Student	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Conv. Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. London, Pa.	
d. STREET ADDRESS 7 X →		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Maggie Belle Lininger		4. DATE OF DEATH Jan. 8 1961	
5. SEX F.		6. COLOR OR RACE W.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 5, 1874	
9. AGE (In years last birthday) 86 yrs		10. IF UNDER 1 YEAR Months 1 Days 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Mt. London, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Lininger		14. MOTHER'S MAIDEN NAME Helen Barger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Helen Lininger, Mt. London, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		19. INTERVAL BETWEEN ONSET AND DEATH 2 years	
DUE TO PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Fracture of Surgical Neck of Femur		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I, if item 18) Fell on floor	
20c. TIME OF INJURY Month Day Year Hour a.m. 1/7 1961 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) Nursing Home		20f. (City or town) (County) (State) Hagerstown Wash. Md.	
21. I certify that (I) (this hospital) attended the deceased from Nov. 8, 1958, to Jan 8, 1961, that (I) (we) last saw the deceased alive on Jan 7, 1961, and that death occurred at 8:30 a.m. from the causes and on the date stated above.		22b. DATE SIGNED 1/10/61	
22a. SIGNATURE David R. Brewer		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) David R. Brewer		22d. ADDRESS Clear Spring Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/14/61	
23c. NAME OF CEMETERY OR CREMATORIAL Stoners Hill Graveyard		23d. LOCATION (City, town, or county) Mt. London, Pa. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Robert R. Barlow		ADDRESS 15-2 S. Second St., Chambersburg, Pa.	
25a. REC'D BY REGISTRAR JAN 12 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	



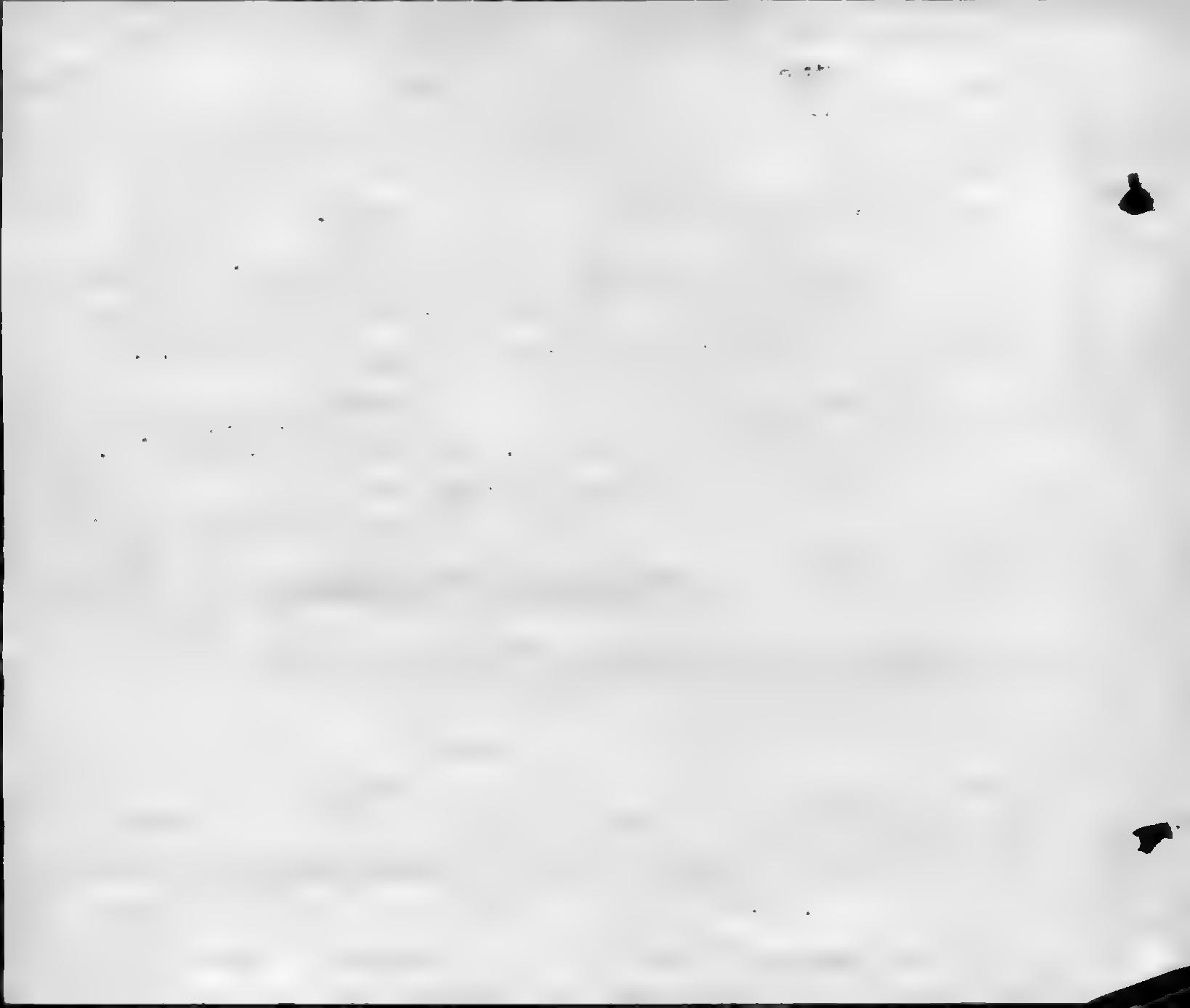
TO HOSPITAL OR **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		1228 Washington		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		MARYLAND 2 weeks		a. STATE Maryland b. COUNTY Washington	
Hagerstown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Hagerstown		d. STREET ADDRESS	
Washington County Hospital		814 Main Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Month	Day
Charles		Henry	Lucas	Jan.	20
4. SEX		5. COLOR OR RACE	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH	8. AGE (in years) IF UNDER 1 YEAR last birthday
Male		White	WIDOWED <input type="checkbox"/>	May 29 1887	9. AGE (in years) IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
Labor		City Hagerstown		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		U.S.A.	
(Unknown)		Lucas		Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		214 09 3758		814 Main Ave. Address Mrs. Susie Lucas Hagerstown Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		214 09 3758 Mrs. Susie Lucas Hagerstown Md.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral hemorrhage, left			
412.1 DUE TO		Arteriosclerotic changes, cerebral			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Arteriosclerotic heart disease			
DUE TO		Chronic and acute passive congestion			
(c)		Indefinite			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Indefinite			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED White Not White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that (I) (this hospital) attended the deceased from December 30, 1961, death, 19, that (I) (we) last saw the deceased alive on January 19, 1961, and that death occurred at 6:35 AM the causes and on the date stated above.		22b. DATE SIGNED January 21, 1961			
22e. SIGNATURE <i>Robert F. Keadle</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 318 North Potomac Street, Hagerstown	
22c. PHYSICIAN'S NAME (Type) Robert F. Keadle, M. D.		23a. BURIAL, CREMATION, REMOVAL (Specify) B Burial Jan. 23-61 Rest Haven Cemetery			
23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Albert Leaf Williamsport Md</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 24 '61	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1229

Item 8 File No. 2-1229-300

CERTIFICATE OF DEATH

300

1215

PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

b. STATE

Maryland Washington

c. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN lb

DCA

d. STREET ADDRESS

115 So Potomac St

e. IS RESIDENCE

ON A FARM?
 YES NO

3. NAME OF DECEASED
 (Type or print)

First

Middle

Last

4. DATE

OF

DEATH

Month

Day

Year

HOYE

ALBERTUS

LUM

January

13 1961

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED

DIVORCED

Oct 18 1900

9. AGE (in years
 lost birthday)

30 yrs

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. BIRTHPLACE (State or foreign country)

USA

13. FATHER'S NAME

Calvin A Lum

14. MOTHER'S MAIDEN NAME

Pearl Mitchell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
 (Yes, no, or unknown)

16. SOCIAL SECURITY NO

17. INFORMANT

Address

No

320-01-4930

Mrs Louise J. Lum 1408 Salem Ave

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a)

465 X

DUE TO

Conditions, if any, which
 gave rise to immediate
 cause (a), stating the under-
 lying cause lost.

(b)

DUE TO

(c)

Hagerstown Md.

INTERVAL BETWEEN
 ONSET AND DEATH
 20 min.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AN AUTOPSY
 PERFORMED?

YES

NO

20a. ACCIDENT WAS UNDERLYING
 OR CONTRIBUTING CAUSE OF DEATH
 (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
 Hour o. m. 19
 p. m.

20d. INJURY OCCURRED
 While Not while
 of work at work

20e. PLACE OF INJURY (Home, farm,
 factory, street, office bldg., etc.)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from January 13, 1961 to Jan. 13, 1961 that (I) (we) last
 saw the deceased alive on Jan. 13, 1961, and that death occurred at 1:50 P.M. from the causes and on the date stated above.

22a. SIGNATURE

B. B. Kneisley, M.D.

M.D.

ATTENDING

PHYS

MED

DIRECTOR

STAFF

PHYS

22b. DATE
 1/14/61

22c. PHYS. CHAN'S
 NAME (Type)

22d. ADDRESS

148 West Washington Street
 Hagerstown, Maryland

23a. BURIAL, CREMATION,
 REMOVAL (Specify)

Burial 1/16/61

23c. NAME OF CEMETERY OR CREMATORI

Rest Haven Cemetery

23d. LOCATION (City, town or county)

(State)

Hagerstown, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Andrew K. Coffman Hagerstown Md.

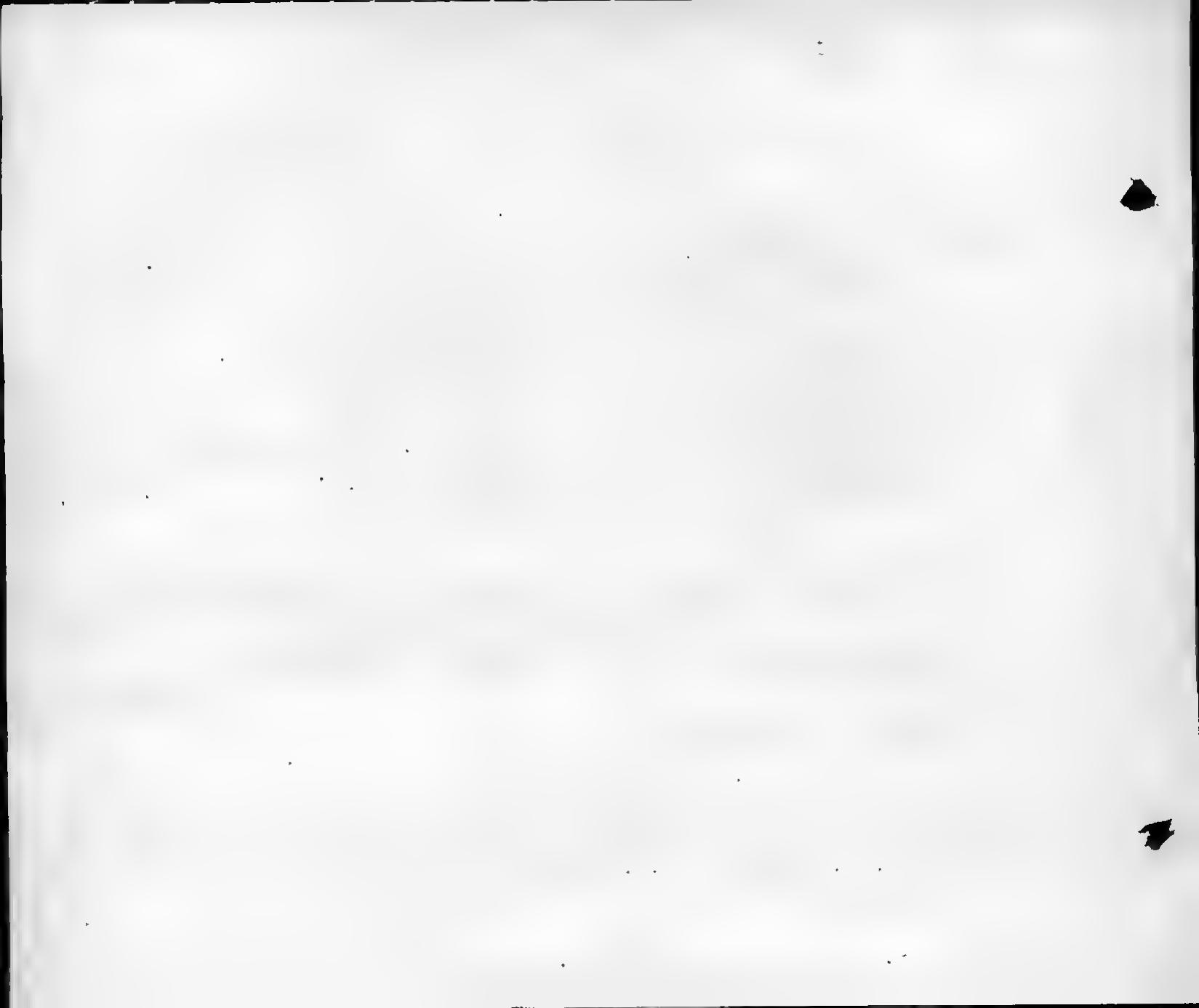
25a. REC'D BY REGISTRAR

JAN 19 '61

DATE

25b. REGISTRAR'S SIGNATURE

John S. Lewis



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

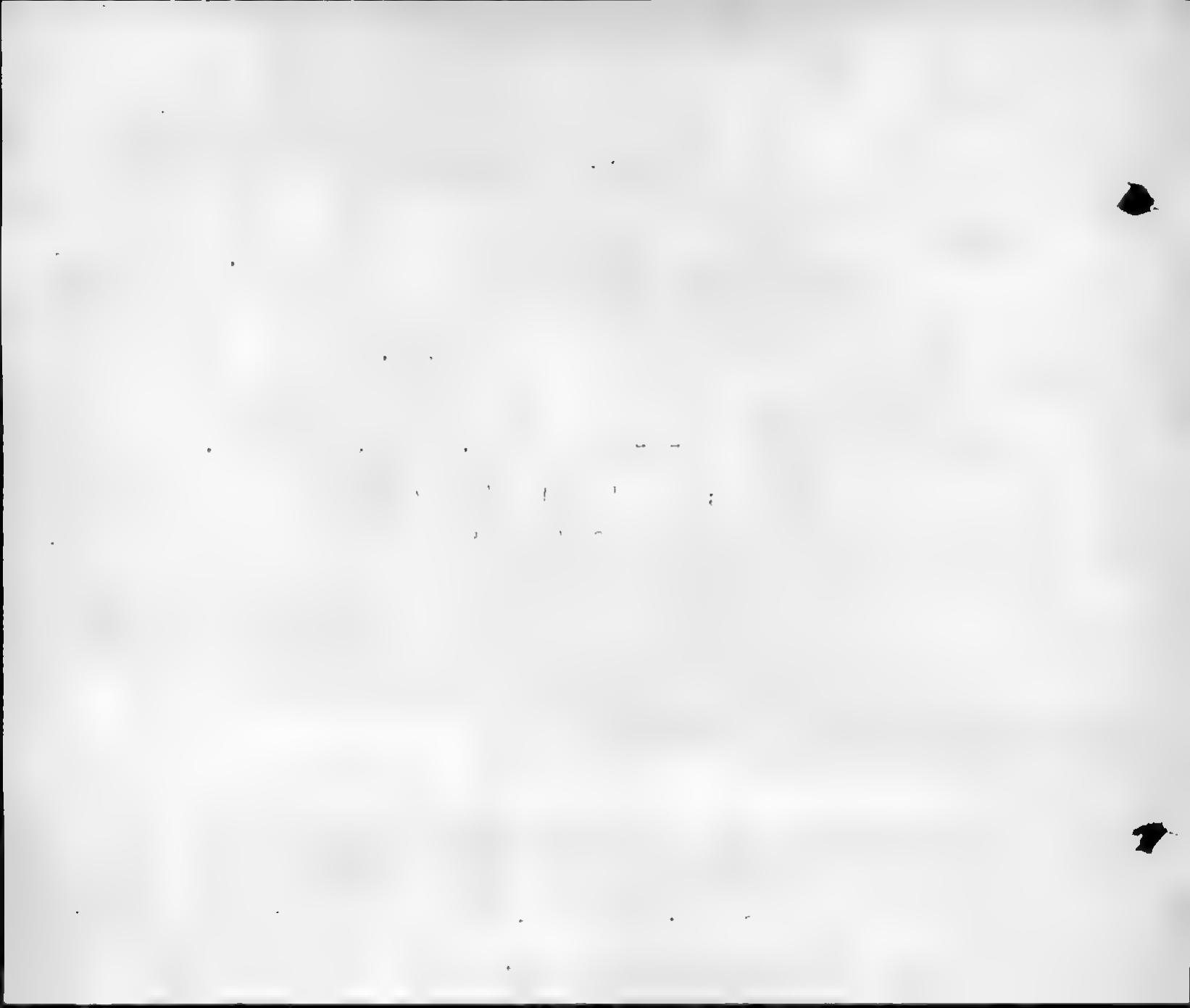
1230 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 1216

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithburg		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithburg	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First VICTOR	Middle MARTIN	Last MANAHAN
4. DATE OF DEATH	Month Jan.	Day 28	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1890
9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
10c. BIRTHPLACE (State or foreign country) Lantz, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Manahan		14. MOTHER'S MAIDEN NAME Amanda Ellen Buhrman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 189-18-6888	17. INFORMANT Harry C. Manahan, Cascade, Md.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 22 <input checked="" type="checkbox"/> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <input type="checkbox"/> DUE TO DUE TO (c) <input type="checkbox"/>		RECENT ALCOHOL INTOXICATION W/FREEZING	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		5 YRS. CARDIO VASCULAR DISEASE	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John S. Becker</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>1/28/61</i>
EXAMINER'S NAME (Type) <i>John S. Becker</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/31/1961	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Moriah Luth. Cemetery	22d. LOCATION (City, town, or county) Foxville (State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>S. Martin Goe</i>	ADDRESS Waynesboro, Penna.	24a. REC'D. BY REGISTRAR JAN 31 1961	24b. REGISTRAR'S SIGNATURE <i>Christine S. Moore</i>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1231

CERTIFICATE OF DEATH

11217

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		b. COUNTY WASHINGTON	
c. LENGTH OF STAY IN lb LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) WESTERN MD. STATE HOSPITAL		d. STREET ADDRESS 1202 E. WASHINGTON ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Bertha	Middle McCurdy	Last
4. DATE OF DEATH	Month January	Day 12	Year 1961
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/29/1880
9. AGE (In Years last birthday) 80 yrs	10. IF UNDER 1 YEAR Months 80 yrs	11. IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEWIS ERNDIE		14. MOTHER'S MAIDEN NAME EMMA TRACEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO NONE	17. INFORMANT MR. JESSE O. McCURDY	18. HAGERSTOWN MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 8 years	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO general arteriosclerosis (c)		CORONARY arteriosclerosis, severe general arteriosclerosis unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ① organized pneumonia, bil. ② cholelithiasis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from NOV 18, 1959, to January 12, 1961, that (I) (we) last saw the deceased alive on January 10, 1961, and that death occurred on 1/12/61, from the causes and on the date stated above		22b. DATE SIGNED January 13, 1961	
22c. SIGNATURE Victor L. Ramos, M.D.		22d. ADDRESS western md. state hospital, Hagerstown, MD.	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1/14/61	23c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEM.	23d. LOCATED ON (City, town, or county) HAGERSTOWN MD.
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Normen, Hagerstown, Md.		25a. ADDRESS ADDRESS	25b. REC'D BY REGISTRAR DATE JAN 16 '61
		25b. REGISTRAR'S SIGNATURE Arline S. Kraus	

TO HOSPITAL
may be recorded by the hospital or attending physician.

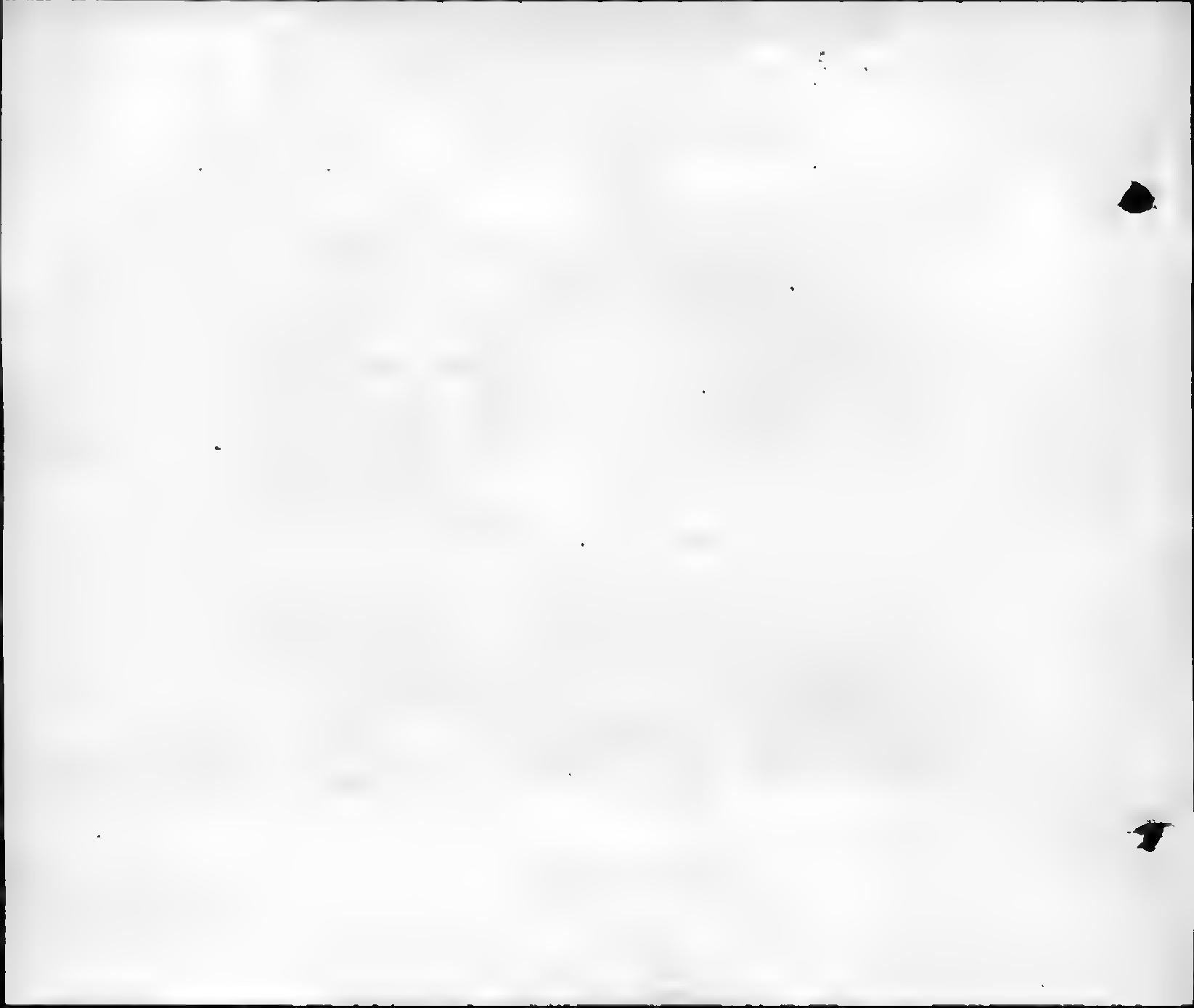
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1 TO HOSPITAL may be rendered by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1232 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH (1218)

1 PLACE OF DEATH a. COUNTY		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		a. STATE b. COUNTY			
Williamsport		1 yr.		W. Va.			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION		e. STREET ADDRESS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Williamsport pavilion		5 Steen's Coal Junction		d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		
Robert		Porterfield		McGarry	January 6, 1961		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) 82 yrs.		
Male		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	May 12 1878	10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS Monthly Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			
Shenandoah Co., W. Va.		Shenandoah Co., W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address			
John D. McGarry		Emma Burr		Robert P. McGarry Jr. - Shenandoah Co., W. Va.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Congestive Heart Failure 3 days					
450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	Generalized atherosclerosis				
		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)					
none							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)			
				20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from _____ to _____, that (1) (we) last saw the deceased alive on _____, and that death occurred at _____ A.M. from the causes and on the date stated above		22b. DATE SIGNED					
22a. SIGNATURE		M.D. <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
M.E. Bynkit		Williamsport Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town, or county) (State)	
Burial		1-9-61		Edge Hill Cemetery		CHARLES TOWN, W. VA.	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Scott Munnich & Son		Fredericktown Md		DATE JAN 11 '61		C. S. Thrall	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1233

CERTIFICATE OF DEATH

(1219)

1. PLACE OF DEATH a. COUNTY		Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB		d. STATE Md.	
Hagerstown		35 years		b. COUNTY Wash.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
409 Guilford Ave.		63 Hagerstown		YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Hattie	Middle Virginia	Last Merckle	4. DATE OF DEATH Month January Day 18 Year 1961
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1883	9. AGE (In years last birthday) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sardis, Ohio	
13. FATHER'S NAME William Sole		14. MOTHER'S MAIDEN NAME Olivia Hoskinson		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) no		16. SOCIAL SECURITY NO none		17. INFORMANT Address Claude Merckle, Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 156.1 Carcinoma of Liver INTERVAL BETWEEN ONSET AND DEATH 8 mo.					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO (c)			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar. 29, 1960 to Jan. 16, 1961 that (I) (we) last saw the deceased alive on Jan. 16, 1961, and that death occurred at 11M, from the causes and on the date stated above.					
22a. SIGNATURE R.A. Bell, M.D.		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 1-20-61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Hagerstown, Maryland.			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 1-21-61		23c. NAME OF CEMETERY OR CREMATORIAL Queens Point Cemetery	
23d. LOCATION (City, town, or county) Keyser, W. Va.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		ADDRESS		25a. REC'D BY REGISTRAR JAN 23 '61	
				25b. REGISTRAR'S SIGNATURE Luther S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1234

(1220)

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN lb

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington County Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

5. SEX

Male

John

Ash

6. COLOR OR RACE

White

WIDOWED

DIVORCED

7. MARRIED NEVER MARRIED

b. DATE OF BIRTH

Jan. 1, 1885

4. DATE
OF
DEATH

January

Day

24

19 61

10a. USUAL OCCUPAT. ON (Give kind of work
done during most of working life, even if retired)

Chest Builder

10b. K ND OF BUSINESS OR INDUSTRY

Pipe Organ Works

11. BIRTHPLACE, County & State, or foreign country

Clearspring, Md.

12. CITIZEN OF WHAT COUNTRY

USA

13. FATHER'S NAME

C. Edward Miller

Lethan Helen Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address Hagerstown, Md.

214-09-7852 Mrs. Ida K. Miller 632 N. Mulberry St.

INTERVAL BETWEEN
ONSET AND DEATH

7 days

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Archib H. Henningsen

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I.e.) 19. WAS AUTOPSY
PERFORMED?YES NO 20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

White

Not White

at work at work 20d. PLACE OF INJURY (Home, farm
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

20e. (CITY OR TOWN)

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20cc. (CITY OR TOWN)

20dd. (CITY OR TOWN)

20ee. (CITY OR TOWN)

20ff. (CITY OR TOWN)

20gg. (CITY OR TOWN)

20hh. (CITY OR TOWN)

20ii. (CITY OR TOWN)

20jj. (CITY OR TOWN)

20kk. (CITY OR TOWN)

20ll. (CITY OR TOWN)

20mm. (CITY OR TOWN)

20tt. (CITY OR TOWN)

20uu. (CITY OR TOWN)

20vv. (CITY OR TOWN)

20ww. (CITY OR TOWN)

20xx. (CITY OR TOWN)

20yy. (CITY OR TOWN)

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20aa. (CITY OR TOWN)

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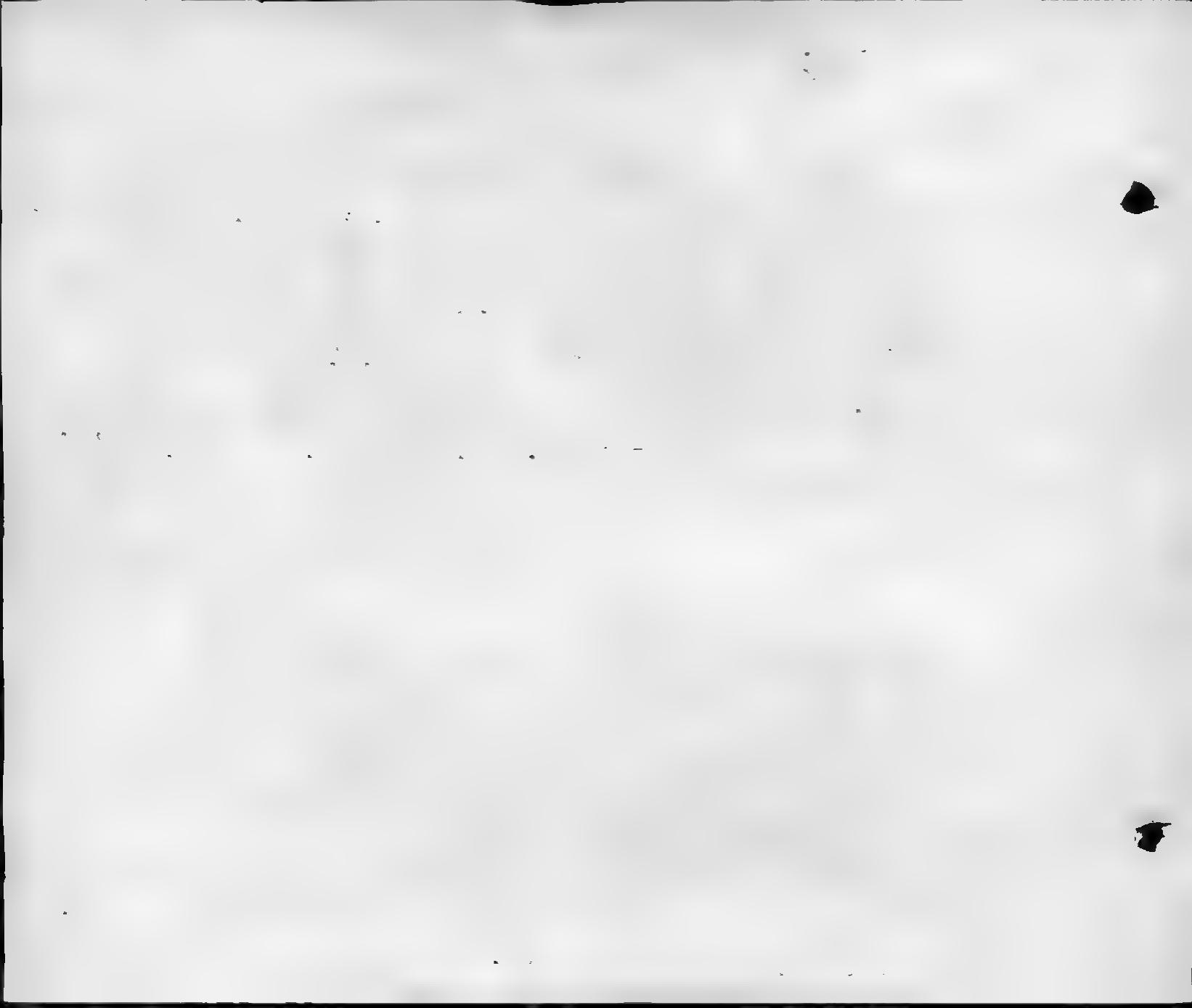
20ee. (CITY OR TOWN)

20ff. (CITY OR TOWN)

20gg. (CITY OR TOWN)

20hh. (CITY OR TOWN)

20ii. (CITY OR TOWN)



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1235

CERTIFICATE OF DEATH

Dr. Rober: Can

(1221)

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 63 Hagerstown										
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital				d. STREET ADDRESS 424 Brewer Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Rosetta		First K.	Middle .	Last Miller	4. DATE OF DEATH January	Month 28	Day 19	Year 61						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 71 yrs.	F UNDER 1 YEAR Months 12	IF UNDER 24 HRS Days 1	IF UNDER 24 HRS Hours 0	Min. 0						
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Lovettsville Va/		12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME James Kidwell				14. MOTHER'S MAIDEN NAME Mary Copper										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Nellie Hann 1132 Pope Ave. Hagerstown Md.		Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 1 week														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension & bronchopneumonia														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19							20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 31 1961, to Jan 28, 1961, that (I) (we) last saw the deceased alive on Jan 28, 1961, and that death occurred at 11:51 AM, from the causes and on the date stated above.									21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
22a. SIGNATURE L. L. Packer Jr.		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/28/61						
22c. PHYSICIAN'S NAME (Type) L. L. Packer Jr. MD		22d. ADDRESS 145 W. Washington St, Hagerstown, Md.												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 30, 1961		23c. NAME OF CEMETERY OR CREMATORIUM Cedar Lawn Cemetery		23d. LOCATION (City, town, or county) Hagerstown, Md.		(State)						
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE 1 '61		25b. REGISTRAR'S SIGNATURE Cirrus L. Fisher								



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read... by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1236

CERTIFICATE OF DEATH

(1222)

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 152 West North St	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ERNEST	Middle McCELEN	Last MOSE	4. DATE OF DEATH	Month January	Day 16	Year 1961
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 21 1893	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hauling		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Sharpsburg Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jerome Mose		14. MOTHER'S MAIDEN NAME Ella Lay Renner					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown No		16. SOCIAL SECURITY NO 314-09-7300		17. INFORMANT Mrs Kathryn F. Mose 152 W. North St		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.0		DUE TO		Hagerstown Md.		INTERVAL BETWEEN ONSET AND DEATH 1h hours	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Peptic Ulcer with Acute Pancreatitis				Recent	
DUE TO		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o m p. m		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
19							
21. I certify that (I) (this hospital) attended the deceased from 1-2-1961 to 1-17-1961, that (I) (we) last saw the deceased alive on 1-17-1961, and that death occurred at 4 PM, from the causes and on the date stated above.							
22a. SIGNATURE <i>E. W. Ditto</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGN'D 1-19-61				
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.		22d. ADDRESS 215 W. Washington St., Hagerstown, Md.					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/30/61	23c. NAME OF CEMETERY OR CREMATORIAL Mt View Cemetery	23d. LOCATION (City, town, or county) Sharpsburg Wash Co Md.	(State)		
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		25a. REC'D BY REGISTRAR JAN 23 '61	25b. REGISTRAR'S SIGNATURE Orville S. Thrane		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1237

CERTIFICATE OF DEATH

1228

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. CO HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro	
3. NAME OF DECEASED (Type or print) NOAH O. MULLENDURE		d. STREET ADDRESS 14 N. KILDIN DRIVE	
4. SEX MALE	5. COLOR OR RACE WHITE	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH MAY 16, 1872
8. AGE (In years last birthday) 85 yrs.		9. IF UNDER 1 YEAR Months 1 Days 23	10. IF UNDER 24 HRS Hours 1 Min 23
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN CHI RNI	
11. BIRTHPLACE (State or foreign country) GARLAND WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? Address	
13. FATHER'S NAME DANIEL MULLENDURE		14. MOTHER'S MAIDEN NAME MARY BEACHLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. -NUN- LEO MULLENDURE Boonsboro MD.	
17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)	
		DUE TO Acute fulminating enteritis Generalized - or Hemorrhages	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute cholecystitis		INTERVAL BETWEEN ONSET AND DEATH 50 minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		(County) Boonsboro (State) MD	
21. I certify that (I) (this hospital) attended the deceased from April 1932 to January 9, 1961 , that (I) (we) last saw the deceased alive on 1-9-1961 , and that death occurred at 12:20 P.M. from the causes and on the date stated above		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE Joseph Secondari		22b. DATE SIGNED 5/16/61	
22c. PHYSICIAN'S NAME (Type) Joseph Secondari, M. D.		22d. ADDRESS 21 North Main Street Boonsboro, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JANUARY 12, 1961	
23c. NAME OF CEMETERY OR CREMATORIUM ROHRSVILLE CEMETERY		23d. LOCATION (City, town, or county) (State) RHRSVILLE WASH. CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John A. Secondari		25a. REC'D BY REGISTRAR JAN 16 '61	
ADDRESS Boonsboro MD.		25b. REGISTRAR'S SIGNATURE John A. Secondari	



TO HOSPITAL: Attending physician: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be recd by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trans t permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1238

CERTIFICATE OF DEATH

(1224)

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital				d. STREET ADDRESS 280 S. Prospect St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LESTER		First CHARLES	Middle MUNDAY	Last MUNDAY	4. DATE OF DEATH JANUARY 21 1961	Month JANUARY	Day 21	Year 1961	
S SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1904		9 AGE (In years lost birthday) 56 yrs	10 IF UNDER 1 YEAR Months 0	11 IF UNDER 24 HRS Days 0	12 HOURS 0	13. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Cold storage door		11 BIRTHPLACE (State or foreign country) Hagerstown, Md.					
13. FATHER'S NAME Norman S. Munday		14. MOTHER'S MAIDEN NAME Annie Moore							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 219-052-451		17. INFORMANT Mrs. Roy L. Smith		Address 1124 Glenwood Ave. Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBULAR PNEUMONIA						INTERVAL BETWEEN ONSET AND DEATH 5 DAYS			
162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) CARCINOMATOSIS						6 MONTHS			
DUE TO (c) BRONCHIOGENIC CARCINOMA RT. LUNG						2 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County) Hagerstown	(State) Md.
21. I certify that (I) (his hospital) attended the deceased from DEC. 28 1960 to JAN. 21 1961 , that (I) last saw the deceased alive on JAN 21 1961 , and that death occurred at 10 PM , from the causes and on the date stated above.									
22a. SIGNATURE Antonio U. Pallagrosi		M.D.		ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED 1/24/61		
22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAGROSI		22d. ADDRESS 1500 PENNSYLVANIA AVE HAGERSTOWN MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/24/61		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION (City, town, or county) Hagerstown, Md.		(State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel		ADDRESS Hagerstown, Md.		25a. REC'D. BY REGISTRAR JAN 24 61		25b. REGISTRAR'S SIGNATURE Arthur S. Moore			
				DATE					



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

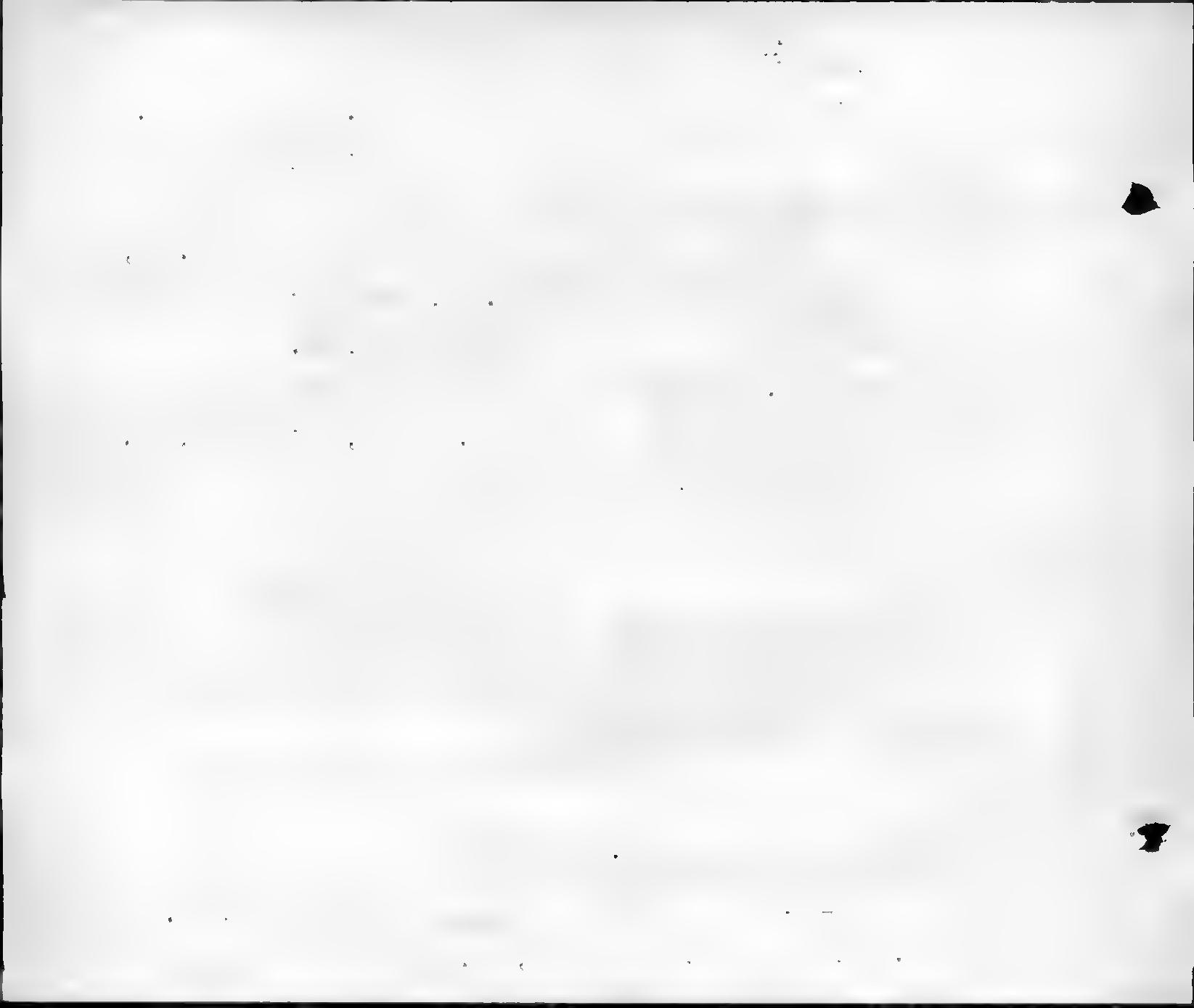
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1239

CERTIFICATE OF DEATH

(1926)

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 21 months		b. COUNTY		Wash.	
Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		rural Smithsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		d. STREET ADDRESS		RFD 1	
Washington County Hospital							
3. NAME OF DECEASED (Type or print)		First Mary	Middle Evelyn	Last Naylor	4. DATE OF DEATH	Month Jan. 21,	Day 1961 Year
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1898		9. AGE (In years last birthday) 62 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Smithsburg, Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Charles S. Hollingsworth		14. MOTHER'S MAIDEN NAME Susie Spessard				Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO none		17. INFORMANT Clyde S. Naylor, Smithsburg, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 572.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 days 5 months	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injuries, Enphysema		21. I certify that (I) (this hospital) attended the deceased from Dec 26, 1960, to Jan 21, 1961, that (I) (we) last saw the deceased alive on Jan 21, 1961, and that death occurred at 9:30 A.M. from the causes and on the date stated above	
22a. MEDICAL CERTIFICATION		20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
22b. SIGNATURE Elvaston R. Lardizabal, M.D.		22c. PHYSICIAN'S NAME (Type) Elvaston R. Lardizabal		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22d. ADDRESS Smithsburg, Md.	
23a. BLR AL. CREMATION REMOVAL (Specify) burial		23b. DATE THEREOF 1-24-61		23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Cemetery		23d. LOCATION (City, town, or county) Smithsburg, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		ADDRESS		25a. REC'D BY REGISTRAR JAN 24 '61		25b. REGISTRAR'S SIGNATURE Clinton F. Minnich	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

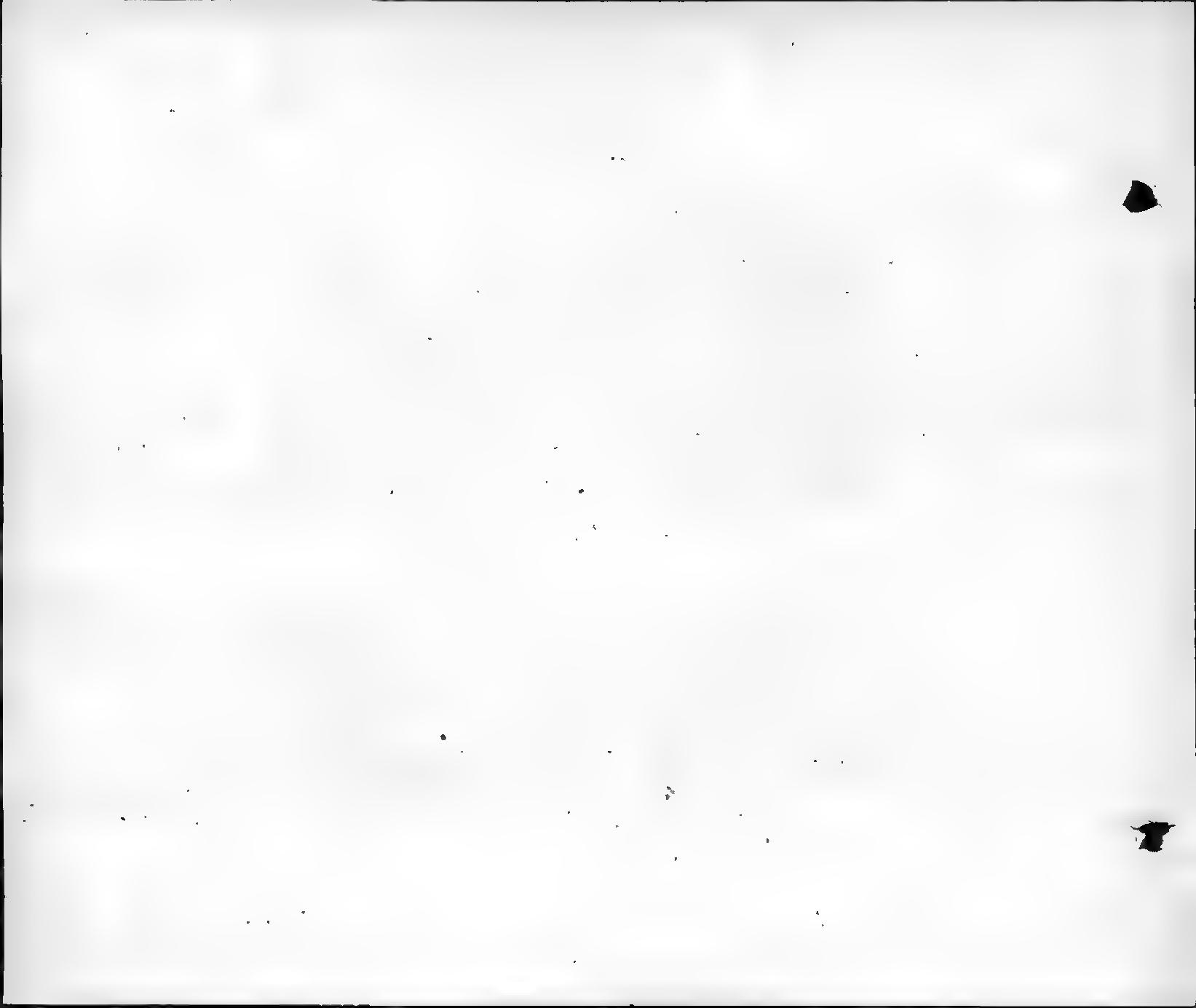
1240

CERTIFICATE OF DEATH

Reg. Dist. No.

(1226)

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
3. NAME OF DECEASED (Type or print) Baby		First Lin	Middle N
4. DATE OF DEATH Month 1		Day 22	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/27/1961
9. AGE (In years lost birthday) yrs	10. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) ---	11. KIND OF BUSINESS OR INDUSTRY ---	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Leo V. Norris	14. MOTHER'S MAIDEN NAME Sharon Fink	15. CITIZEN OF WHAT COUNTRY? U.S.	
16. SOCIAL SECURITY NO. ---	17. INFORMANT ---	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 769.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c) Hypertension & Atletism Diabetes, Maternal	
19. INTERVAL BETWEEN ONSET AND DEATH 3 days			20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-26, 1961, to 1-28, 1961, that I last saw the deceased alive on 1-28, 1961, and that death occurred at 4:45 M, from the causes and on the date stated above		22. ACTUAL SIGNATURE D. J. Boyer M.D. 135 1/2 St. Hagerstown, Md.	
23. PHYSICIAN'S NAME (Type) Dr. D. J. Boyer		24. ADDRESS 135 1/2 St. Hagerstown, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/30/1961	
22c. NAME OF CEMETERY OR CREMATORIUM Rohrersville Cemetery		22d. LOCATION (City, town, or county) Rohrersville, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co. Middletown, Md.		24a. REC'D BY REGISTRAR DATE JAN 31 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please render carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1241

CERTIFICATE OF DEATH

(125)

1. PLACE OF DEATH o COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 16 1 yr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont rural	
d. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10 X-2		11/1961	
3. NAME OF DECEASED (Type or print)	First George	Middle Thomas	Last PENWELL
4. DATE OF DEATH	Month 1	Day 11	Year 1961
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1896
9. AGE (In years at last birthday) 64 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY State roads	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Penwell		14. MOTHER'S MAIDEN NAME Edith Stitley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Roger Penwell		Address Thurmont, Md. RD 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 527-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH one week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from NOV. 23, 1959, to Jan. 11, 1961, that (I) (we) last saw the deceased alive on Jan. 11, 1961, and that death occurred at 1:16 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun		22b. DATE SIGNED Jan. 11, 1961	
22c. PHYSICIAN'S NAME (Type) Young E. Chun		ATTENDING PHYS. <input type="checkbox"/> M.D.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS 1500 Penna. Ave. Hagerstown, Md.
23a. BURIAL, CREMATION b. c. (Specify) burial		23b. DATE THEREOF 1-14-61	
23c. NAME OF CEMETERY OR CREMATORIAL Blue Ridge Cemetery		23d. LOCATION (City, town, or county) Thurmont, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond S. Creager		25a. REC'D BY REGISTRAR DATE JAN 13 '61	
ADDRESS Thurmont, Md.		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	



1
FOR STATE
HEALTH DEPT.

is necessary,
Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MEDICAL CERTIFICATION

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1242 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000, 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1000, 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1070, 1071, 1072, 1073, 1074, 1075, 1076, 1077, 1078, 1079, 1070, 1071, 1072, 1073, 1074, 1075, 1076, 1077, 1078, 1079, 1080, 1081, 1082, 1083, 1084, 1085, 1086, 1087, 1088, 1089, 1080, 1081, 1082, 1083, 1084, 1085, 1086, 1087, 1088, 1089, 1090, 1091, 1092, 1093, 1094, 1095, 1096, 1097, 1098, 1099, 1090, 1091, 1092, 1093, 1094, 1095, 1096, 1097, 1098, 1099, 1100, 1101, 1102, 1103, 1104, 1105, 1106, 1107, 1108, 1109, 1100, 1101, 1102, 1103, 1104, 1105, 1106, 1107, 1108, 1109, 1110, 1111, 1112, 1113, 1114, 1115, 1116, 1117, 1118, 1119, 1110, 1111, 1112, 1113, 1114, 1115, 1116, 1117, 1118, 1119, 1120, 1121, 1122, 1123, 1124, 1125, 1126, 1127, 1128, 1129, 1120, 1121, 1122, 1123, 1124, 1125, 1126, 1127, 1128, 1129, 1130, 1131, 1132, 1133, 1134, 1135, 1136, 1137, 1138, 1139, 1130, 1131, 1132, 1133, 1134, 1135, 1136, 1137, 1138, 1139, 1140, 1141, 1142, 1143, 1144, 1145, 1146, 1147, 1148, 1149, 1140, 1141, 1142, 1143, 1144, 1145, 1146, 1147, 1148, 1149, 1150, 1151, 1152, 1153, 1154, 1155, 1156, 1157, 1158, 1159, 1150, 1151, 1152, 1153, 1154, 1155, 1156, 1157, 1158, 1159, 1160, 1161, 1162, 1163, 1164, 1165, 1166, 1167, 1168, 1169, 1160, 1161, 1162, 1163, 1164, 1165, 1166, 1167, 1168, 1169, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1200, 1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1200, 1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 1248, 1249, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 1248, 1249, 1250, 1251, 1252, 1253, 1254, 1255, 1256, 1257, 1258, 1259, 1250, 1251, 1252, 1253, 1254, 1255, 1256, 1257, 1258, 1259, 1260, 1261, 1262, 1263, 1264, 1265, 1266, 1267, 1268, 1269, 1260, 1261, 1262, 1263, 1264, 1265, 1266, 1267, 1268, 1269, 1270, 1271, 1272, 1273, 1274, 1275, 1276, 1277, 1278, 1279, 1270, 1271, 1272, 1273, 1274, 1275, 1276, 1277, 1278, 1279, 1280, 1281, 1282, 1283, 1284, 1285, 1286, 1287, 1288, 1289, 1280, 1281, 1282, 1283, 1284, 1285, 1286, 1287, 1288, 1289, 1290, 1291, 1292, 1293, 1294, 1295, 1296, 1297, 1298, 1299, 1290, 1291, 1292, 1293, 1294, 1295, 1296, 1297, 1298, 1299, 1300, 1301, 1302, 1303, 1304, 1305, 1306, 1307, 1308, 1309, 1300, 1301, 1302, 1303, 1304, 1305, 1306, 1307, 1308, 1309, 1310, 1311, 1312, 1313, 1314, 1315, 1316, 1317, 1318, 1319, 1310, 1311, 1312, 1313, 1314, 1315, 1316, 1317, 1318, 1319, 1320, 1321, 1322, 1323, 1324, 1325, 1326, 1327, 1328, 1329, 1320, 1321, 1322, 1323, 1324, 1325, 1326, 1327, 1328, 1329, 1330, 1331, 1332, 1333, 1334, 1335, 1336, 1337, 1338, 1339, 1330, 1331, 1332, 1333, 1334, 1335, 1336, 1337, 1338, 1339, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1400, 1401, 1402, 1403, 1404, 1405, 1406, 1407, 1408, 1409, 1400, 1401, 1402, 1403, 1404, 1405, 1406, 1407, 1408, 1409, 1410, 1411, 1412, 1413, 1414, 14



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1243

30

(122)

PLACE OF DEATH to COUNTY Washington		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) to STATE Maryland		b COUNTY Washington	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 21 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 129 E. Antietam St	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 159 E. Antietam St				d. STREET ADDRESS 129 E. Antietam St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print)	First HOWARD	Middle LAWSON	Last POMPELL	4. DATE OF DEATH January 26 1961	Month 1	Day 19	Year 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6 1895		9. AGE (In years from last birthday) 65 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY Taxi Cab		11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Pompell							
14. MOTHER'S MAIDEN NAME Bessie Wilkinson							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-6739		17. INFORMANT Mrs C. Catherine Pompell		Address 129 E. Antietam St Hagerstown	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 143 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (a) b DUE TO c PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I (c) On this 26th day of Jan 1961 in Hagerstown Md.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o.m. p.m.	Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown	(County) Wash Co	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 25</u> to <u>Jan 26</u> , 1961, that (I) (we) last saw the deceased alive on <u>Jan 25</u> , 1961, and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Louis G. Graff</u>				M.D. <input checked="" type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE 1961		
22c. PHYSICIAN'S NAME (Type) <u>Louis G. Graff</u>				22d. ADDRESS <u>129 E. Antietam St Hagerstown Md.</u>			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 1/30/61		23c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		23d. LOCATION (City, town, or county) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 30 '61	25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4
may be received by the Capitol or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1230

1 PLACE OF DEATH a. COUNTY		Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission) a. STATE		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 48 years		b. COUNTY		Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		935 Concord		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown	
3 NAME OF DECEASED (Type or print)		First Bessie	Middle Elizabeth	Last Potts	4. DATE OF DEATH	January	Month 10 Day 1961 Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1879		9. AGE (In years last birthday) 81 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jacob Marteney		14. MOTHER'S MAIDEN NAME Adeline Williams		Address Mrs. Betty Showe Hagerstown, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Multiple Sclerosis (c) DUE TO arteriosclerosis, cerebral	
19. MEDICAL CERTIFICATION		20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20d. DATE 1961	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Hagerstown		(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 25</u> 1960, to <u>Jan 25</u> 1961, that (I) (we) last saw the deceased alive on <u>Dec 25</u> 1960, and that death occurred at <u>Hagerstown</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Philip J. Hirshman</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 1/10/61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 159 W. Washington St. Hagerstown, Maryland					
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 1-12-61		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION (City, town, or county) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DAJAN 12 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Knapp	



1
TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1245 11251

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington									
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Rural Hagerstown		c. LENGTH OF STAY IN 1b 4 years		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Hagerstown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hagerstown		d. STREET ADDRESS Hagerstown Rt. 6		4. DATE OF DEATH January 19 1961		Month Day Year									
3. NAME OF DECEASED (Type or print) Herman		First Middle Last		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 13, 1887		9. AGE (In years 1st birthday) 78 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY General work		11. BIRTHPLACE (State or foreign country) New York N.Y.		12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME Ted Ramp		14. MOTHER'S MAIDEN NAME Mary Stoll		15. ADDRESS Hagerstown Rt. 6											
16. SOCIAL SECURITY NO 579-05-7212		17. INFORMANT Mrs. Mary E. Ramp		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardiac Dis 420.05 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 4 mo.									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Oct 7, 1960 to Jan 18, 1961, that (I) (we) last saw the deceased alive on Jan 18, 1961, and that death occurred at 69M, from the causes and on the date stated above		22a. SIGNATURE David R. Brewer		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 1/20/61									
22c. PHYSICIAN'S NAME (Type) David R. Brewer		22d. ADDRESS Clear Spring Md.													
23a. BURIAL/CREMAT. ON/REMOVAL (Specify) Burial		23b. DATE THEREOF 1-22-61		23c. NAME OF CEMETERY OR CREMATORIAL Broadfording Cemetery		23d. LOCATION (City, town or county) Washington Co. Md. (State)									
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich		ADDRESS 7 son Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JAN 24 '61		25b. REGISTRAR'S SIGNATURE Charles S. Evans									



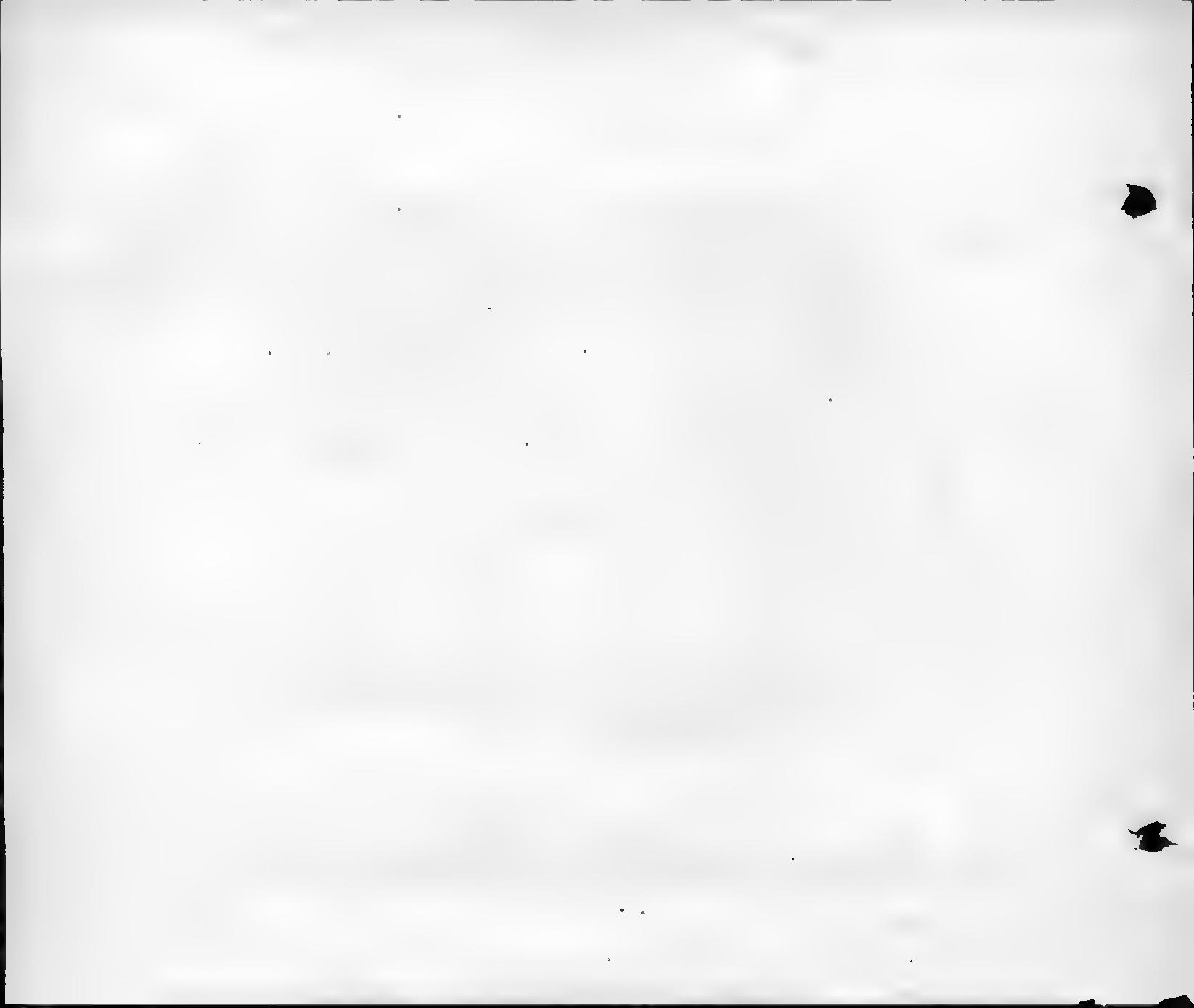
TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in by the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1950 CERTIFICATE OF DEATH (1252)

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Maugansville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Nursing Home			d. STREET ADDRESS Main St.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Charles	Middle Edgar	Last Riggs	4. DATE OF DEATH 1	Month Day 29 Year 19 61	
5. SEX male	6. COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-24-1879		9. AGE (in years last birthday) 81 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired clerk		10b. KIND OF BUSINESS OR INDUSTRY Leiter Bros.		11. BIRTHPLACE (State or foreign country) Montgomery Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis B. Riggs			14. MOTHER'S MAIDEN NAME Amanda Nicholson			Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or date of service) no		16. SOCIAL SECURITY NO 217-05-9911		17. INFORMANT Mrs. Nell Riggs		18. INTERVAL BETWEEN ONSET AND DEATH One week	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cerebral Hemorrhage (c)			Branched Cerebral Cerebral Hemorrhage			7 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-12-1959 to 1-29-1961, that (I) (we) last saw the deceased alive on 1-25-1961, and that death occurred at 11 A.M. from the causes and on the date stated above						22b. DATE SIGNED	
22a. SIGNATURE J. E. W. D. D.			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) Dr. E. W. D. D.		22d. ADDRESS Hagerstown Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 2-16-61		23c. NAME OF CEMETERY OR CREMATORIUM St. Pauls Cemetery		23d. LOCATION (City, town, or county) Hagerstown Rural (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss			ADDRESS Hagerstown, Md.			25a. REC'D BY REGISTRAR DATE FEB 2 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kraiss



FOR STATE
HEALTH DEPT.

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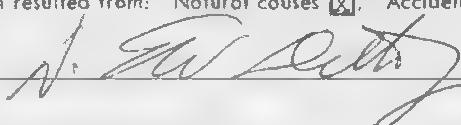
1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

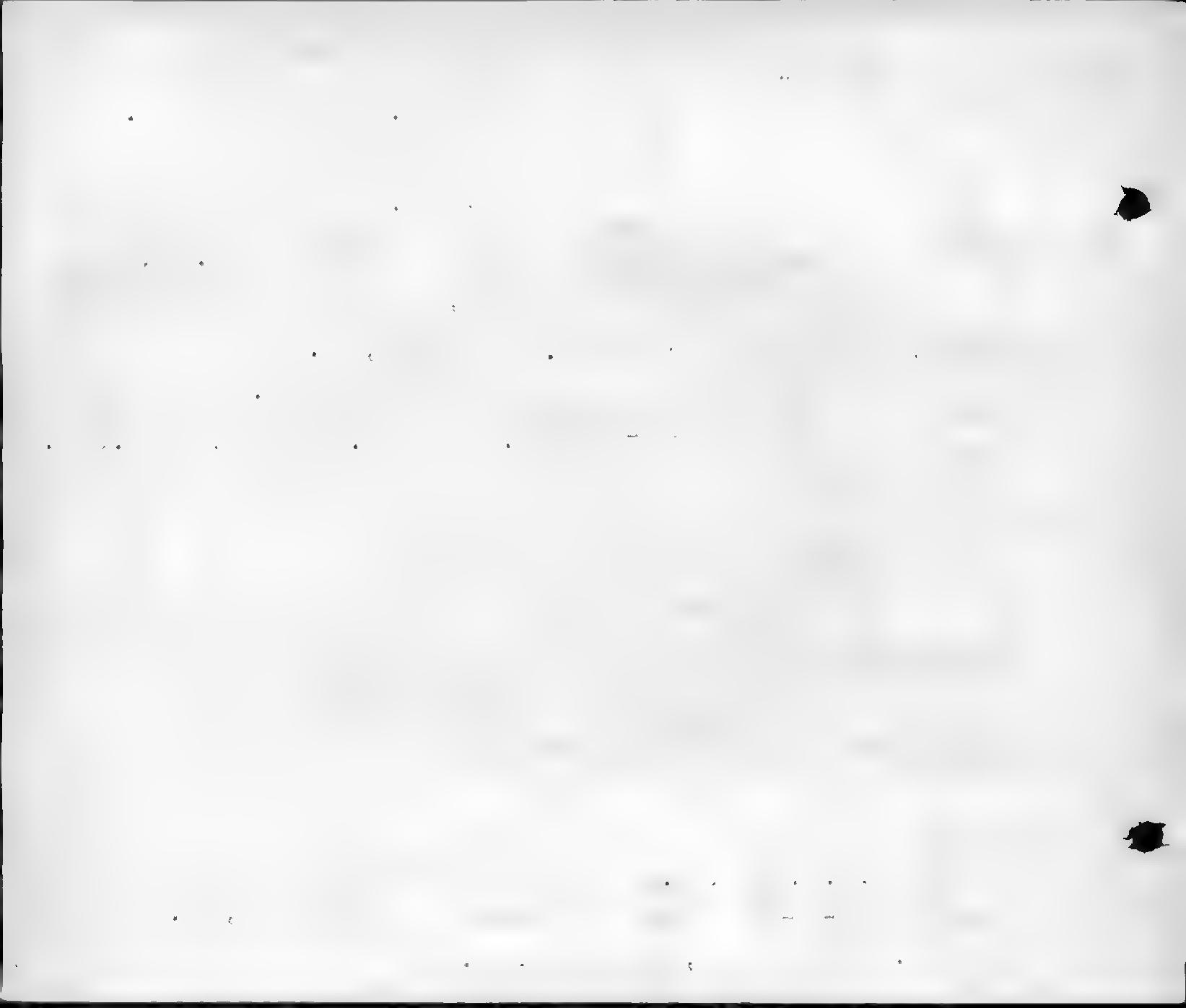
Reg. Dist. No. 1253

1247

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Balt.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cavetown	c. LENGTH OF STAY IN 1b 9 hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS 311 S. Parrish	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Clarence Henry Rudisill	First Middle Last	4. DATE OF DEATH Jan. 14, 1961			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1904	9. AGE (In years less birthday) 56 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machine operator	10b. KIND OF BUSINESS OR INDUSTRY plastics mfg.	11. BIRTHPLACE (State or foreign country) Smithsburg, Md.	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Joseph Rudisill	14. MOTHER'S MAIDEN NAME Elvie M. Popper				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO 217-26-0824	17. INFORMANT Mrs. Harriet B. Rudisill, Balt., Md.	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart Disease, recent</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE 	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED 1-16-61			
EXAMINER'S NAME (Type) Dr. W. F. Dittie, Jr.	22a. BURIAL, CREMATION, REMOVAL (Specify) buried	22b. DATE THEREOF 1-17-61	22c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Cemetery	22d. LOCATION (City, town, or county) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 18 '61	24b. REGISTRAR'S SIGNATURE C. W. S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1248

CERTIFICATE OF DEATH

Reg. Dist. No. (1254)

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Virginia</i>		b. COUNTY <i>Warren</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		c. LENGTH OF STAY IN 1b <i>2 mos.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverton</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington County Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>CHARLES</i>	Middle <i>WILLIAM</i>	Last <i>ST. JOHN</i>	4. DATE OF DEATH Month <i>Jan.</i>	Day <i>6</i>	Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>June 24, 1882</i>	9. AGED (In years last birthday) <i>78</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Night Watchman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Limestone Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Patrick St. John</i>		14. MOTHER'S MAIDEN NAME <i>Mary Cuddren</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or date of service)		17. INFORMANT <i>Miss Mildred St. John, Hagerstown, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart Disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>1-2 yrs.</i>							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) <i>generalized arteriosclerosis</i>		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Benign Prostate by hypertrophy</i> <i>Sensitivity</i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov 2</i> , 1960, to <i>Jan 6</i> , 1961, that I last saw the deceased alive on <i>Jan 6</i> , 1961, and that death occurred at <i>4:30</i> P.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>Edward W. Dith III, M.D. 212 W. Washington St. Hagerstown, MD</i>							
DATE SIGNED <i>1/6/61</i>							
ACTUAL SIGNATURE <i>Edward W. Dith III</i>		PHYSICIAN'S NAME (Type) <i>Edward W. Dith III, M.D. Hagerstown, MD</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/9/61</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Prospect Hill</i>		22d. LOCATION (City, town, or county) <i>Front Royal, Virginia</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Madley Funeral Home, P.R.A. Robertson</i>		ADDRESS <i>100 Main Street, Hagerstown, MD</i>		24a. REC'D BY REGISTRAR <i>Jan 10 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Price</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1249

CERTIFICATE OF DEATH

(1255)

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret Irene Shipley		4. DATE OF DEATH Jan. 22 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 26 1917	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Silk Mill	
11. BIRT PLACE (County & State, or foreign country) Funkstown Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander N. Moore		14. MOTHER'S MAIDEN NAME Heide Irene Dixon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213 16 0353	
17. INFORMANT Mr. Harold W. Shipley		Address 102 E. Salisbury Street, Williamsport Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. } DUE TO (b) DUE TO (c) DUE TO Metastatic Carcinoma Cervical Carcinoma		INTERVAL BETWEEN ONSET AND DEATH Cancer 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cachexia			
20a. ACCIDENT WAS UNDERLYING CAUSE OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 8, 1960 to Jan. 22, 1961, that (I) (we) last saw the deceased alive on Jan. 21, 1961, and that death occurred at 7:30a.m. from the causes and on the date stated above.			
22a. SIGNATURE ME Byrd		22b. DATE SIGNED 1-23-61	
22c. PHYSICIAN'S NAME (Type) ME Byrd Kit		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 28 W Potowac Wmpt 140	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 25-61	
23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Cemetery		23d. LOCATION (City, town or county) Williamsport Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Bilie V. Lea - Williamsport Md.		ADDRESS	
		25a. REC'D BY REGISTRAR DATE JAN 26 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Knapp	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 156 E Main St.		e. STREET ADDRESS 156 E. Main St.	
3. NAME OF DECEASED (Type or print) Ella Catherine Shives		4. DATE OF DEATH 1 24 1961	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 22, 1880	
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Hancock, Maryland U.S.A.	
13. FATHER'S NAME Charles Vantz		14. MOTHER'S MAIDEN NAME Elizabeth Vantz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ethel Maria Shives, 156 E Main St.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)	
DUE TO Cardiovascular arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 days	
DUE TO Diarrhea and lithites			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 21, 1961 to April 24, 1961 , that (I) (we) last saw the deceased alive on April 21, 1961 , and that death occurred at 11 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 1/25/61	
22a. SIGNATURE LM Shaffer		22b. ATTENDING MED STAFF PHYS DIRECTOR PHYS	
22c. PHYSICIAN'S NAME (Type) LM Shaffer		22d. ADDRESS Hancock, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) 156181		23b. DATE THEREOF 1/27/61	
23c. NAME OF CEMETERY OR CREMATORIAL St. Peters Cemetery		23d. LOCATION (City, town, or county) Hancock	
24. FUNERAL DIRECTOR'S SIGNATURE Howard J. Shaffer Hancock, MD		25a. ADDRESS 25b. REC'D BY REGISTRAR DATE Arthur S. Koenig JAN 31 '61	
25c. REGISTRAR'S SIGNATURE Arthur S. Koenig			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1251

CERTIFICATE OF DEATH

Reg. Dist. No. 11201

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Friderick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro		c. LENGTH OF STAY IN 1b 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown		d. STREET ADDRESS 11 X	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Reeder Nursing Home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lucy		First	Middle C.	Losi	4. DATE OF DEATH 1 15	Month	Day Year 1961
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/11/1878		9. AGE (In years (If birthday) 02 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or Foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Bowlus				14. MOTHER'S MAIDEN NAME Amanda Sigler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> no		16. SOCIAL SECURITY NO none		17. INFORMANT Harold Sigler, Boonsboro, Md., Route 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) + 2000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) DUE TO } (c) DUE TO Arteriosclerotic heart disease -						INTERVAL BETWEEN ONSET AND DEATH 8 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Toxins in right tip						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-2-1961 to 1-15-1961, that I last saw the deceased alive on 1-14-1961, and that death occurred at 11:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Joseph Secondari, M. D.						ADDRESS (Street, city or town, state) 21 North Main Street DATE SIGNED 1/17/61	
PHYSICIAN'S NAME (Type) Joseph Secondari, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/18/1961		22c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery		22d. LOCATION (City, town, or county) Middletown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company		ADDRESS Middletown, Md.		24a. REC'D BY REGISTRAR DATE JAN 19 '61		24b. REGISTRAR'S SIGNATURE O'Brien & Hayes	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1252

CERTIFICATE OF DEATH

1208

1. PLACE OF DEATH
a. COUNTY

Washington

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington County Hospital

3. NAME OF
DECEASED
(Type or print)

ALICE

First

Middle

MARY

SPIELMAN

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED

8. DATE OF BIRTH

DIVORCED 9. DATE
OF
DEATH

January

Last

Month

Day

19 19 61

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE County & State or foreign country

Everett, Penna.

13. FATHER'S NAME

John Perrin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give rank or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

220-30-9791

Miss Edna Spielman

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

332X

DUE TO

Conditions, etc. which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Cerebral thrombosis

Astrocytoma.

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Hypertension

YES NO 19. WAS AUTOPSY
PERFORMED?

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)

20c. TIME OF INJURY
Hour e.m.
p.m.20d. INJURY OCCURRED
While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 28 Dec 1960 to 15 Jan 1961, that (I) (we) last
saw the deceased alive on 18 Jan 1961, and that death occurred at 2:30 PM, from the causes and on the date stated above.

22a. SIGNATURE

Eldon S Hoachlander

ATTENDING
PHYS.

22d. ADDRESS

MED
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED23a. BURIAL, CREMATION, REMOVAL
(Specify)

Burial

1/22/61

23c. NAME OF CEMETERY OR CREMATORIUM

Rest Haven Cemetery

23d. LOCATION (City, town or county)

Hagerstown,

(State)

Md.

24. FUNERAL DIRECTOR'S SIGNATURE

Rest Haven Funeral Chapel Hagerstown, Md.

ADDRESS

25a. REC'D BY REGISTRAR

DATE JAN 23 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

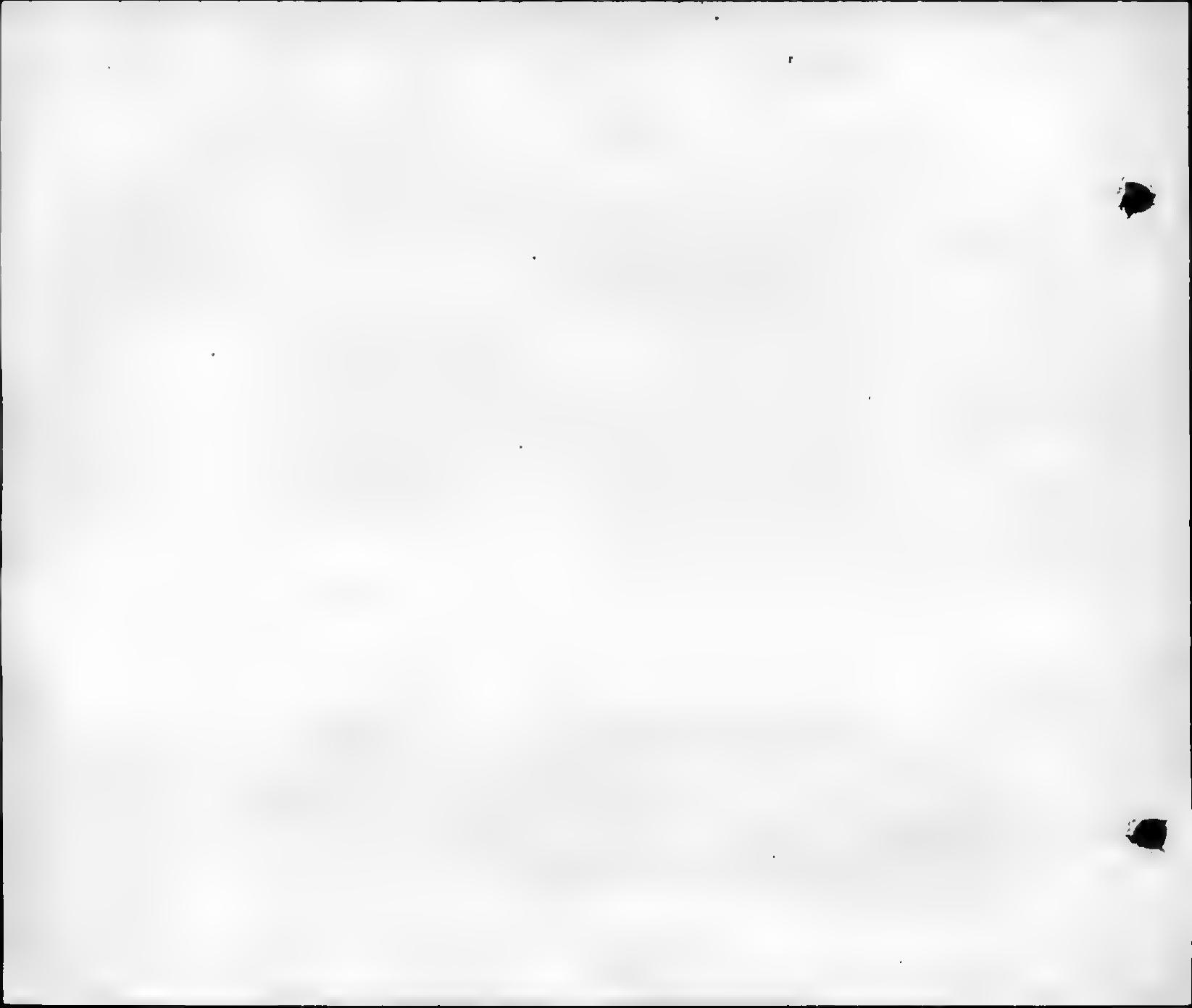


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1253 (1253)

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Williamsport		c. LENGTH OF STAY IN 1b		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Williamsport	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 2			d. STREET ADDRESS Route 2		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Leon Daniel Stahl		First	Middle	Lost	4. DATE OF DEATH January 26 1961
5. SEX Male White		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 31, 1901	9. AGE (In years lost birthday) 59 yrs.
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nachinist	
10b. KIND OF BUSINESS OR INDUSTRY Aircraft		11. BIRTHPLACE (State or foreign country) Washington County Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Fred R. Stahl			14. MOTHER'S MAIDEN NAME Emma K. Wolfensberger		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 573-07-8912		17. INFORMANT Mrs. Missouri Stahl Williamsport, Id	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO myocardial infarction INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- (b) Arteriosclerosis - Generalized 5 yrs. lying cause lost. (c)			ONSET AND DEATH 5 hrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) left hemiplegia due to cerebral thrombosis					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from May 16, 1951, to Jan. 26, 1961, that (I) (we) last saw the deceased alive on Jan. 26, 1961, and that death occurred at 10 P.M. from the causes and on the date stated above.					
22a. SIGNATURE		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Lloyd A. HOFFNER Hagerstown, Md.					
23a. BURIAL/CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF 1-29-61		23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Cemetery	
23d. LOCATION (City, town or county) (State) Williamsport, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS					
Scott F. Minnich & Son Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE JAN 30 '61	
				25b. REGISTRAR'S SIGNATURE Charles S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1254

CERTIFICATE OF DEATH

11240

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b Life		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 837 Concord			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
3. NAME OF DECEASED (Type or print) Nellie Forrest Startzman			d. STREET ADDRESS 837 Concord St.		
4. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			First	Middle	Last
5. SEX Female			6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1878
9. AGE (In years last birthday) 92 yrs			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Hagerstown, Md.
12. CITIZEN OF WHAT COUNTRY? None			13. FATHER'S NAME Calvin Middlekauff		
14. MOTHER'S MAIDEN NAME Cornelia Kuhn			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Miss Cornelie Startzman Ha. Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			19. INTERVAL BETWEEN ONSET AND DEATH 10 yrs Arterio sclerosis heart disease		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Obesity Hypertension			21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)		
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/25/61 to 12/30/61, that (I) (we) last saw the deceased alive on 25 Nov 1961, and that death occurred at 3:30 AM from the causes and on the date stated above.			22. SIGNATURE Eldon D Hoachlander		
22c. PHYSICIAN'S NAME (Type)		M.D.	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 11/31/61	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 2-1-61	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	23d. LOCATION (City, town, or county) Hagerstown, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Linnich & Son			ADDRESS Hagerstown, Md.	25a. REC'D BY REGISTRAR FEB 1 '61	25b. REGISTRAR'S SIGNATURE James S. Frame



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 4, 21, 22b film G-79 1-16-61 et

1241

CERTIFICATE OF DEATH

Reg. Dist. No.

1255

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/58

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) b. STATE	
Washington MARYLAND		Maryland Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Rural		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville- Rural	
3. NAME OF DECEASED (Type or print)		First	Middle
MARY V. Stottlemeyer			Last
4. DATE OF DEATH		Month	Day
Dec. 7, 1961		Jan.	7
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
Female White			
8. DATE OF BIRTH		9. AGE (In years lost birthday) November 26, 1873-87 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired housewife		11. BIRTHPLACE (State or foreign country) Frederick Co. Md	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Scott Martin		14. MOTHER'S MAIDEN NAME Mary Ellen Buhrman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	INFORMANT Address
		none	Frank V. Stottlemeyer, Myersville, Md.
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
Arterial Sclerotic Heart Disease			
DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
Dec. 7, 1961 19			
21. I certify that I attended the deceased from <u>Dec. 7, 1961</u> to <u>Dec. 7, 1961</u> , that I last saw the deceased alive on <u>Dec. 7, 1961</u> , and that death occurred at <u>11-5500</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. Clear Spring Md.	
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) David R. Brewer		DATE SIGNED 1/8/61	
22a. BUR. CREMAT. ON, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 10, 1961	22c. NAME OF CEMETERY OR CREMATORIUM United Brethren
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Paul F. Bittle	22d. LOCATION (City, town, or county) Wolfsville Fred. Co., Md.
			24a. REC'D BY REGISTRAR DATE JAN 10 '61
			24b. REGISTRAR'S SIGNATURE Charles S. Turner



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1256

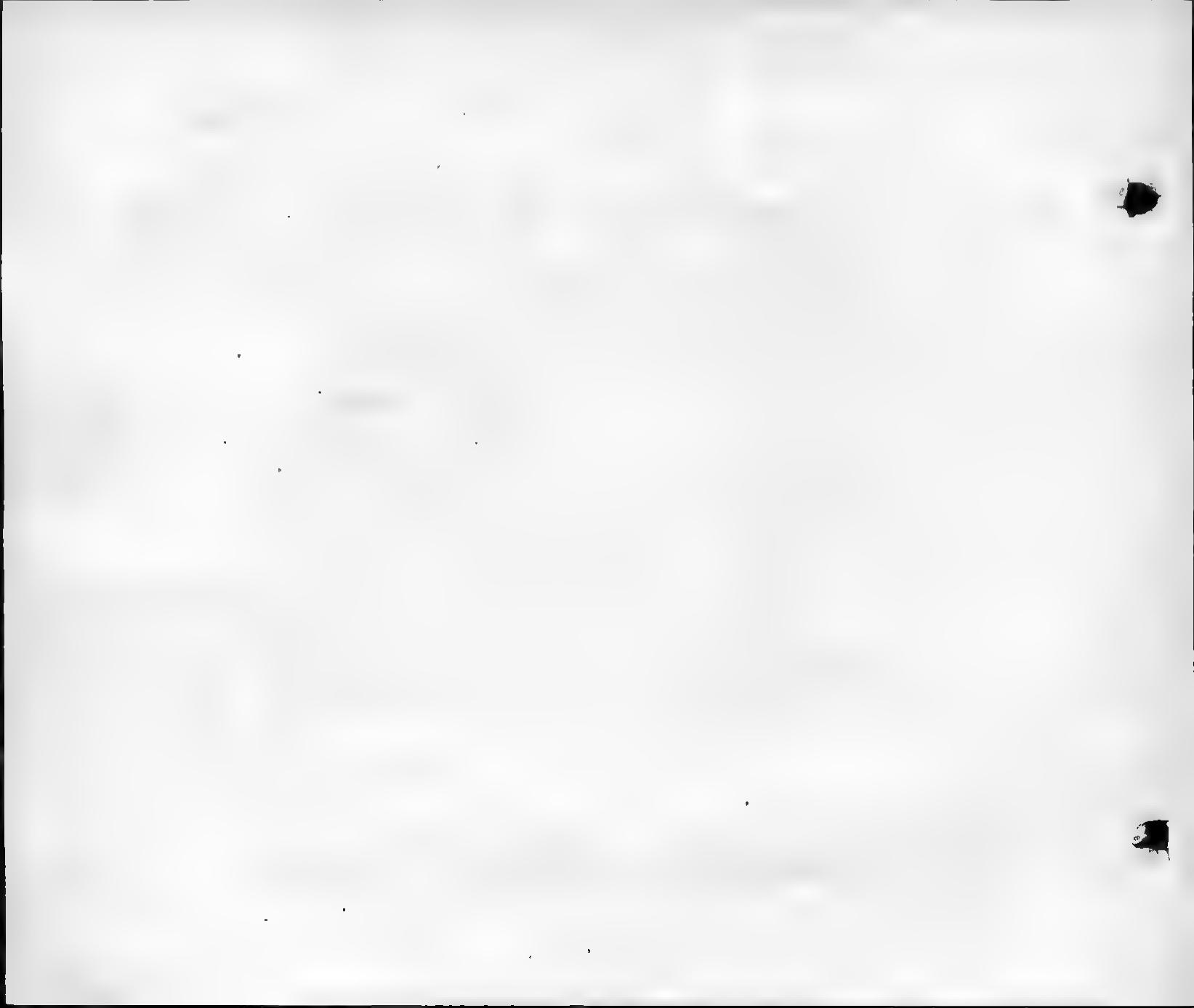
CERTIFICATE OF DEATH

124

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 2 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reeder Nursing Home		d. STREET ADDRESS 542 Pangborn Blvd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First GRACE	Middle VIRGINIA	Last STOUFFER
4. DATE OF DEATH	Month January	Month 15	Day 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feby 15 1883
9. AGE (In years last birthday) 78 yrs	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Fairplay Wash Co Md.
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Albertus Stouffer		
14. MOTHER'S MAIDEN NAME Larth Danner	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO -----	17. INFORMANT Mrs Nellie Andrews	Address 542 Pangborn Blvd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Hypertensive cardio-vascular			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Boonsboro	(County) Wash Co	(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Dec 10 1961 to Jan 15 1961, that (I) (we) last saw the deceased alive on Jan 13 1961, and that death occurred at 8 P.M. from the causes and on the date stated above.			
22a. SIGNATURE G. Wilhelm		22b. DATE 1/16/61	
22c. PHYSICIAN'S NAME (Type) G. Wilhelm		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Boonsboro	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 1/18/61	23c. NAME OF CEMETERY OR CREMATORIAL Boonsboro Cemetery	23d. LOCAT ON (City, town, or county) Boonsboro Wash Co Md.
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Cofinan	ADDRESS Hagerstown Md.	25a. REC'D BY REGISTRAR DATE JAN 19 '61	25b. REGISTRAR'S SIGNATURE C. C. K. 3. K. H.

TO HOSPITAL
may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

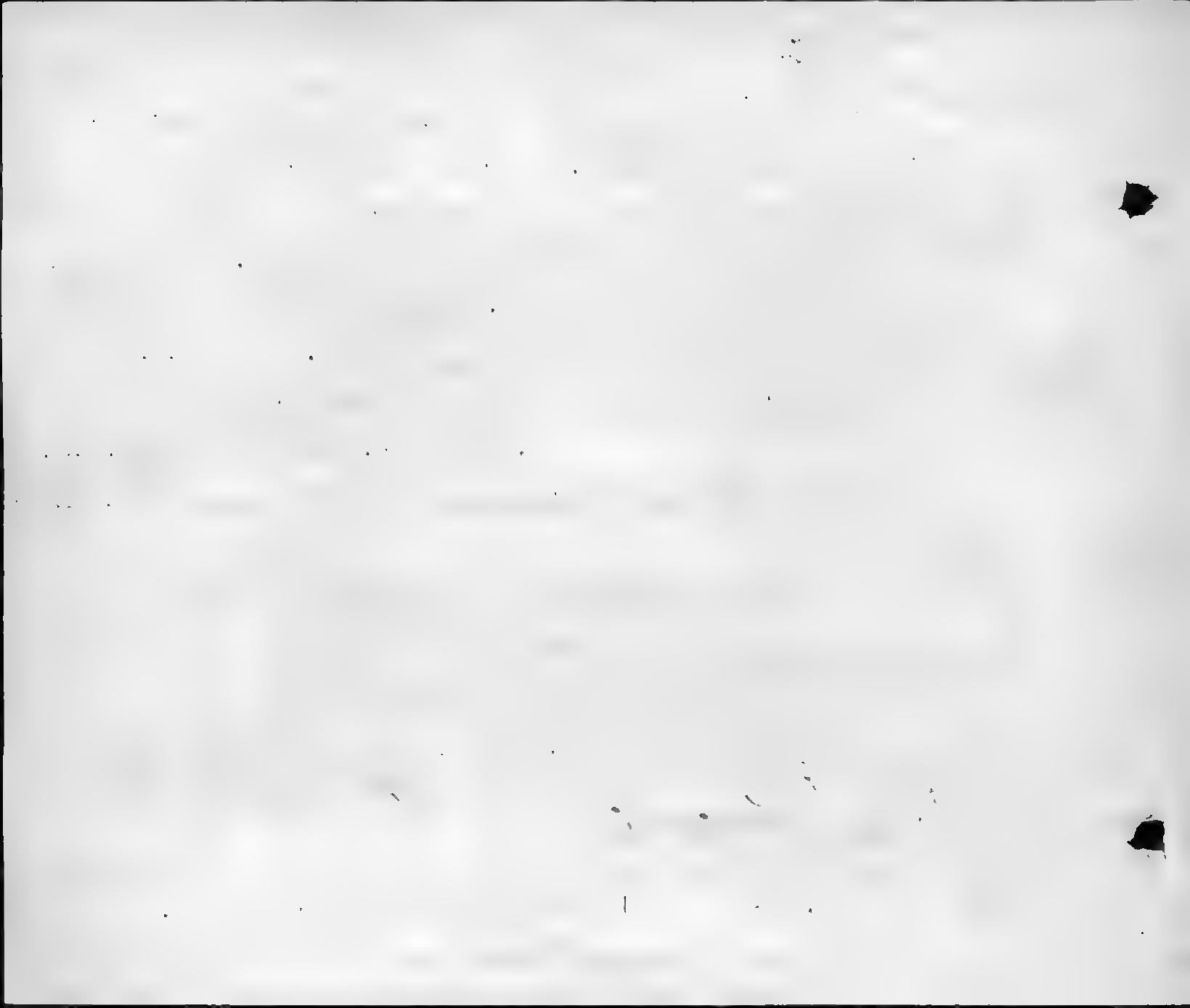
1257

CERTIFICATE OF DEATH

1243

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Washington		e. STATE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Maryland	
Rural Williamsport		b. COUNTY	
c. LENGTH OF STAY IN 16		Washington	
40 yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		X Rural Williamsport RFD #1	
Pinesburg Williamsport RFD #1		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
First Lillie		Middle Mae	
4. DATE OF DEATH		Month Jan. Day 24 Year 19 61	
5. SEX		a. DATE OF BIRTH	
Female		b. DATE OF BIRTH	
6. COLOR OR RACE		9. AGE (in years) IF UNDER 1 YEAR	
White		b. DATE OF BIRTH	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. AGE (in years) IF UNDER 1 YEAR	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		b. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		11. BIRTHPLACE (County & State, or foreign country)	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
Edward Connell		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Mr. Charles J. Teach	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Pinesburg Williamsport, Md.	
420.1		RFD #1	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b)		Mr. Charles J. Teach	
DUE TO (c)		Williamsport, Md.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
Hour a.m. 19 p.m.		20d. INJURY OCCURRED	
White at work		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)	
Not White at work		20f. (City or town)	
21. I certify that (I) (this hospital) attended the deceased from		20g. (County)	
19., and that death occurred at		(State)	
22a. SIGNATURE		22b. DATE SIGNED	
Ralph F. Young M.D.		1961	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
Ralph F. Young M.D.		101 E. Potomac St., Williamsport, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE THEREOF	
Burial		Jan. 26-61	
23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)	
Rest Haven Cemetery		Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
Bainie V. Leaf Williamsport Md.		25b. REGISTRAR'S SIGNATURE	
ADDRESS		DATE JAN 25 '61	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1258

1244

1. PLACE OF DEATH

a. COUNTY

Washington

b. CITY OR TOWN (if out of corporate lim is, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN lb

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington County Hospital

3. NAME OF

DECEASED

(Type or print)

First

Middle

SHIRLEY

LORRAINE

WEST

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

 NEVER MARRIED b. DATE OF BIRTH WIDOWED DIVORCED

Last

R.F.D. # 1

Month

8

Year 1961

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Homemaker

13. FATHER'S NAME

Alvey C. Morgan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

no

16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), setting the
cause last.

(b)

DUE TO

(c)

17. INFORMANT

18. SOCIAL SECUR TY NO

219-20-3326

19. AGE (In years
last birthday)

39 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

Pneumonia, left lobes

Atelectasis

Pulmonary infarction

Rheumatic heart disease, inactive

INTERVAL BETWEEN
ONSET AND DEATH

8 days

same

same

indefinite

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OP. CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b)

20c. TIME OF INJURY Month, Day, Year

Hour a.m. White Not White
p.m. 19 at work at work

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Autust 1960, to death 19, that (I) (we) last saw the deceased alive on January 8, 1961, and that death occurred at 1:50 PM the causes and on the date stated above.

22a. SIGNATURE

Robert F. Keadle

ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS. 22b. DATE
SIGNED
January 9, 196122c. PHYSICIAN'S
NAME (Type)

Robert F. Keadle

Hagerstown, Maryland

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

1/11/1961

23b. DATE THEREOF

Boonsboro Cemetery

23d. LOCATION (City, town or county)

Boonsboro

(State)

Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Suter - Rouzer Funeral Home

ADDRESS

Hagerstown, Md.

25a. REC'D BY REGISTRAR

DATE JAN 12 '61

1961

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

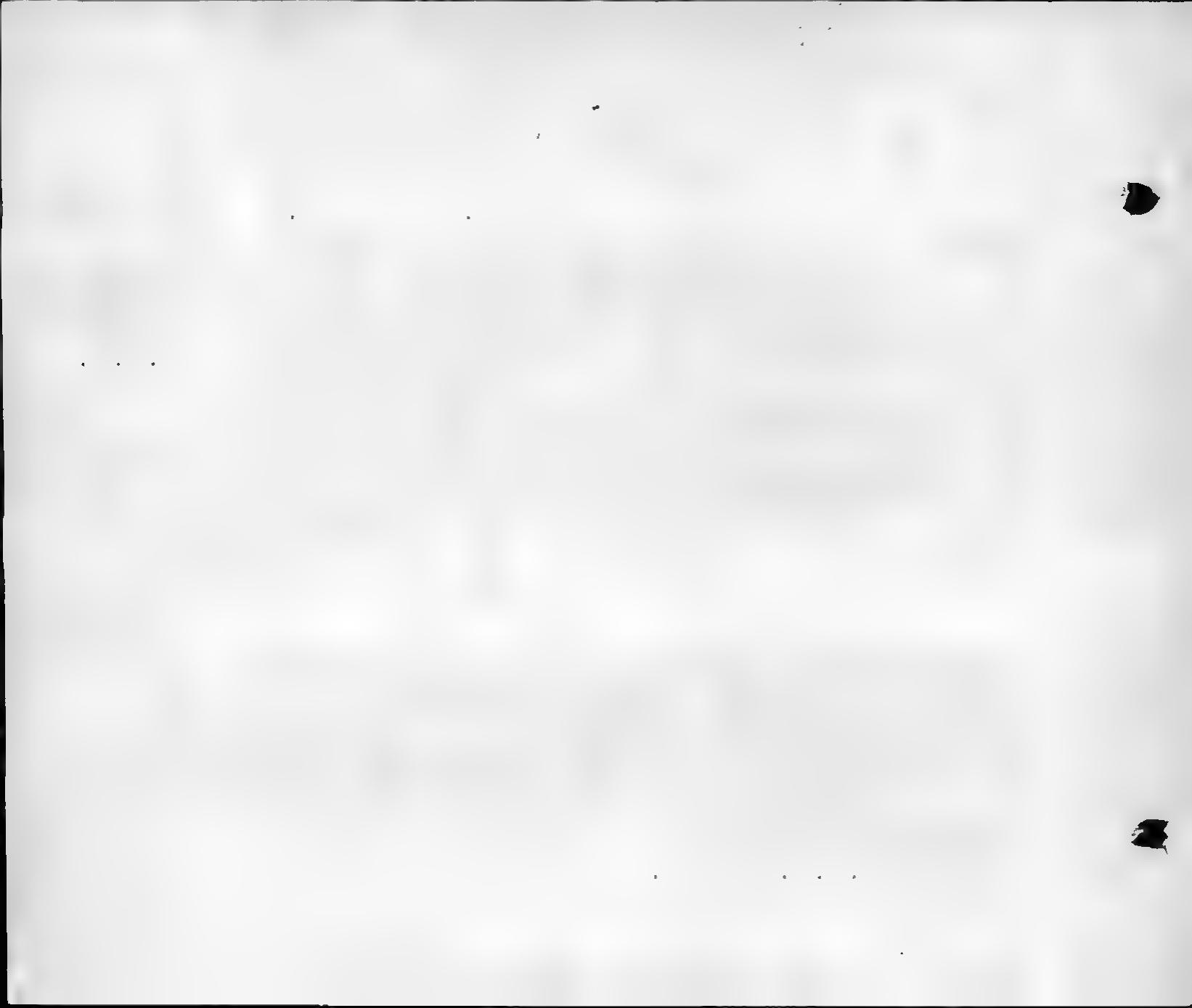
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 124

1259

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 22 N. Washington St.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hotel Hamilton				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Aldred		First	Middle	Lost	4. DATE OF DEATH January 21, 1961	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 2-21-82	9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Practical Nurse		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Not Known				14. MOTHER'S MAIDEN NAME Not Known				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Fitzgerald (Welfare worker)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Dr. F. J. Datto, Jr.</i>		DATE SIGNED 1-2-61						
EXAMINER'S NAME (Type) Dr. F. J. Datto, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL CREMATION, REMOVAL (Specify) 11-10-61		22b. DATE THEREOF 11-10-61		22c. NAME OF CEMETERY OR CREMATORIUM Volney Med. School		22d. LOCATION (City, town, or county) Baltimore, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 17 '61		24b. REGISTRAR'S SIGNATURE C. W. S. Frazee		



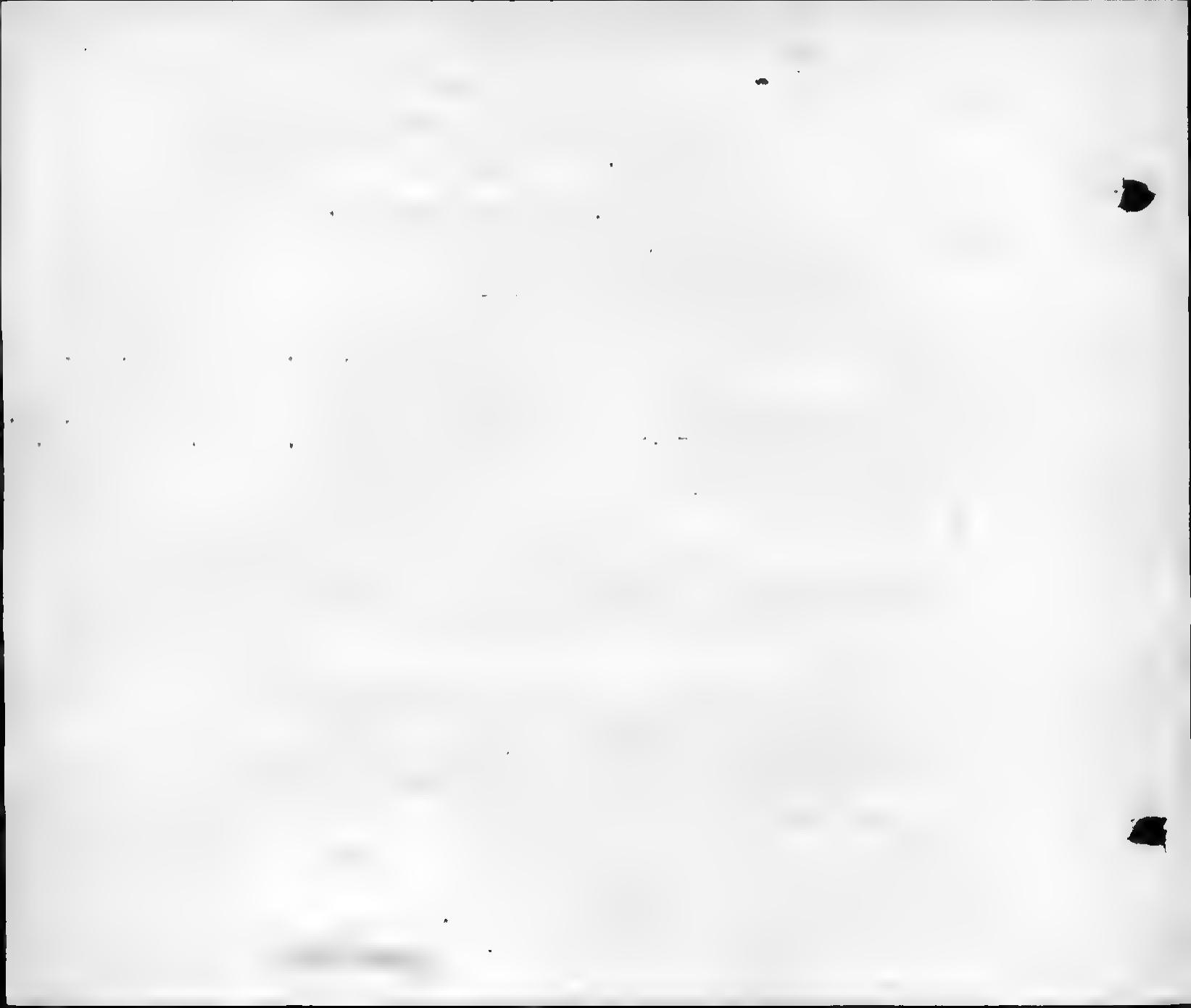
TO HOSPITAL: _____ by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1260		11246													
1. PLACE OF DEATH a. COUNTY Washington				MARYLAND				2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Maryland				b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 mo.				c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) Frostburg				d. STREET ADDRESS 101 Bowery St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Western Maryland) Hagerstown State Hospital Rt. 11												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Herbert	Middle Elroy	Last WINTERS	4. DATE OF DEATH /		Month /	Day 4	Year 1961						
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-4-1910		9. AGE (In years last birthday) 50 yrs		10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS Days 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Brick Works		11. BIRTHPLACE (State or foreign country) Cresaptown, Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		Address Cumberland, Ind. 504 N. Centre St.,							
13. FATHER'S NAME James Albert Winters		14. MOTHER'S MAIDEN NAME Myrtle Hite		15. SOCIAL SECURITY NO 214-14-7706				16. INFORMANT Mrs. Blaine Leasure		17. INFORMANT					
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c)] 1 PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH one week				20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)				21. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from Sept. 19, 1960, to Jan. 4, 1961, that (I) (we) last saw the deceased alive on Jan. 4, 1961, and that death occurred at 5:25 A.M. from the causes and on the date stated above		22a. SIGNATURE Young E. Chan M.D.				20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
22c. PHYSICIAN'S NAME (Type)		23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 1/7/61		23c. NAME OF CEMETERY OR CREMATORIAL Eckhart Cemetery, Eckhart, Ind.		23d. LOCATION (City, town, or county) 1500 Penna. Ave., Hagerstown, Md.		24. FUNERAL DIRECTOR'S SIGNATURE Ernest Legerton Frostburg Md.		25a. REC'D BY REGISTRAR DATE JAN 10 '61		25b. REGISTRAR'S SIGNATURE C. C. & T. Inc.	
ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1261

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		b. COUNTY WASHINGTON	
c. LENGTH OF STAY IN 1b ONE WEEK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. CO. HOSPITAL		d. STREET ADDRESS 1115 MT. AETNA ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HARRY GARFIELD	First	Middle	Last
4. DATE OF DEATH JANUARY 8 1961	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH OCTOBER 26, 1850
8. WIDOWED <input type="checkbox"/>	9. DIVORCED <input type="checkbox"/>	10. AGE (In years last birthday) 61 yrs.	11. IF UNDER 1 YEAR Months 2 Days 12 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) BELIVILLE FARM, CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? Address: 2235 VIRGINIA AVENUE, HAGERSTOWN, MD	
13. FATHER'S NAME CHASE PHUS WISE		14. MOTHER'S MAIDEN NAME SUSAN GROSS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. CATHARAN REPHY, HAGERSTOWN, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease DUE TO Acute myocardial infarction degenerate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Middle (State) MD	
21. I certify that (I) (this hospital) attended the deceased from 1961 to 1961 , that (I) (we) last saw the deceased alive on 1961 , and that death occurred 1961 M. from the causes and on the date stated above			
22a. SIGNATURE John H. Sperry		22b. DATE SIGNED 1961	
22c. PHYSICIAN'S NAME (Type) John H. Sperry		22d. ADDRESS	
23a. BUR. AL. CREMAT. ON. <input type="checkbox"/> REMOVAL (Specify) 1961		23b. DATE THEREOF JAN. 10, 1961	
23c. NAME OF CEMETERY OR CREMATORIAL LOTHIAN CEMETERY		23d. LOCATION (City, town, or county) (State) MIDDLETON Twp. CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John H. Sperry		25d. REC'D BY REGISTRAR DATE JAN 16 '61	
ADDRESS Boonsboro Rd. MP.		25b. REGISTRAR'S SIGNATURE John H. Sperry	



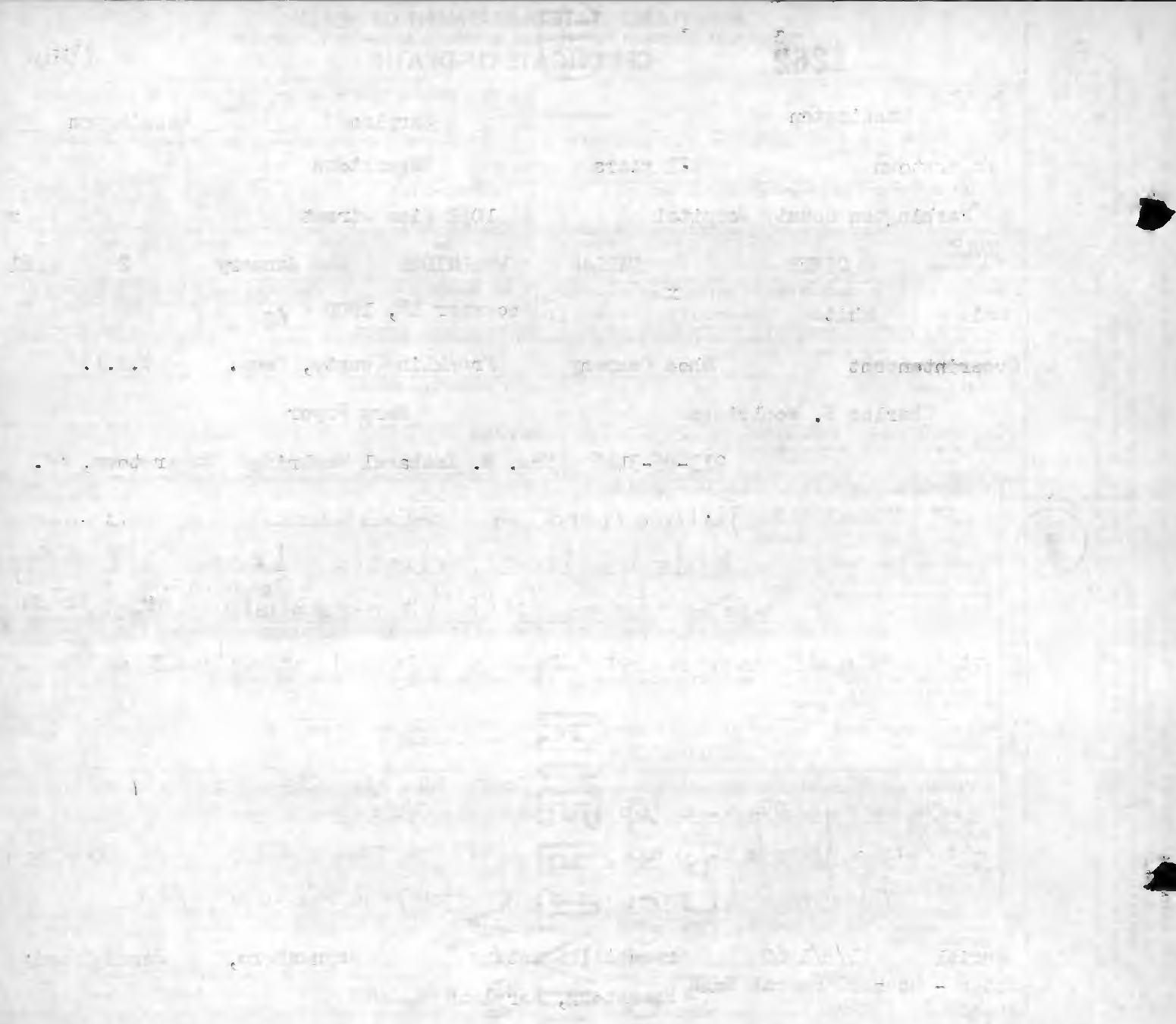
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11248

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 21 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. STREET ADDRESS 1052 View Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CLYDE	Middle HARLAN	4. DATE OF DEATH Month January
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 18, 1900
9. AGE (In years last birthday) 60	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent	11. KIND OF BUSINESS OR INDUSTRY Shoe Company	12. BIRTHPLACE (State or foreign country) Franklin County, Penn.
13. FATHER'S NAME Charles E. Woolridge	14. MOTHER'S MAIDEN NAME Mary Pryor		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 213-05-3148	17. INFORMANT Mrs. M. Isabel Woolridge	Address Hagerstown, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 578X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO Pulmonary Embolus PhleboThrombosis, Legs operations - ① Pt. Colectomy ② closure of cecum, 15 days			
INTERVAL BETWEEN ONSET AND DEATH 5 minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Adeno-Carcinoma of Cecum - recent operation for			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 14, 1960 to Jan. 2, 1961 , that (I) (we) last saw the deceased alive on Jan. 1, 1960 , and that death occurred at 7:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Richard V. Hauver		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Jan. 3, 61
22c. PHYSICIAN'S NAME (Type) Richard V. Hauver		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/5/1960	23c. NAME OF CEMETERY OR CREMATORIAL Greenhill Cemetery
23d. LOCATION (City, town, or county) Waynesboro, Pennsylvania		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home		ADDRESS Hagerstown, Maryland	25a. REC'D BY REGISTRAR DATE JAN 4 '61
			25b. REGISTRAR'S SIGNATURE Arthur S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

61249

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 40 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
3. NAME OF DECEASED (Type or print) RUBY MOTTER		First YOST	Middle YOST
4. DATE OF DEATH JANUARY 2 1961		Last YOST	Month JANUARY
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/5/1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SERETERY		10b. KIND OF BUSINESS OR INDUSTRY UTILITY CO.	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
13. FATHER'S NAME JOHN R. HOEFLICH		14. MOTHER'S MAIDEN NAME MARY RESSER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-10-55164	17. INFORMANT Mrs. MILDRED PERHAM
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 6 hrs.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Arteriosclerotic Heart Disease Arteriosclerosis Arteriosclerotic Heart Disease		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis Arteriosclerotic Heart Disease Arteriosclerosis Arteriosclerotic Heart Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 25 1960 to Jan. 2 1961 that (I) never last saw the deceased alive on Jan. 2 1961 and that death occurred at 20 M. from the causes and on the date stated above.		22b. DATE SIGNED 1/3/61	
22a. SIGNATURE Ed A. Hoffner		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 214 N. Potomac st. Hagerstown
22c. PHYSICIAN'S NAME (Type) Ed A. Hoffner		23d. LOCATION (City, town, or county) WAYNESBORO PENNA.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/4/61	23c. NAME OF CEMETERY OR CREMATORIAL GREEN HILL CEM.
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Kornement, Hagerstown, Md.		25a. ADDRESS ADDRESS	25b. REC'D BY REGISTRAR DATE JAN 5 '61
			25b. REGISTRAR'S SIGNATURE John S. Kornement

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